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SCANNING THE MEDICAL LITERATURE

Abstracts of Papers Written by Rhode Islanders

AN OCULAR STUDY OF PULSELESS DISEASE. Joseph L. Dowling, Jr. and Taylor R. Smith. Arch. Ophth. 64:236, 1960.

Pulseless disease (aortic arch syndrome) is an extreme and dramatic form of chronic circulatory insufficiency. It is characterized clinically by the absence of detectable pulses and inability to measure blood pressure in the arms and neck, and pathologically by obstruction of the major vessels arising from the arch of the aorta. Two types of the disease occur. The first is inflammatory and has been found usually in young adult Japanese women. The occlusive lesion is a diffuse and nonspecific arteritis. The second type is occlusive vascular disease without inflammation. It occurs in males and females especially during the fifth and sixth decade and is characterized by a selective occlusion of the main arterial trunks from the arch of the aorta. Ocular abnormalities are a common feature of pulseless disease. The early symptoms are those associated with cerebral and retinal artery hypotension, namely syncope, vertigo, blurring of vision, and transient amaurosis. The prolonged retinal arterial hypotension produces structural changes in the eye and particularly in the retina. Injection of India ink into the central retinal artery and vein of a patient with pulseless disease demonstrated a typical hypotensive retinopathy consisting of multiple microaneurysms, irregularly dilated veins with segmented blood flow, and decreased central retinal artery pressures (Figure 1).

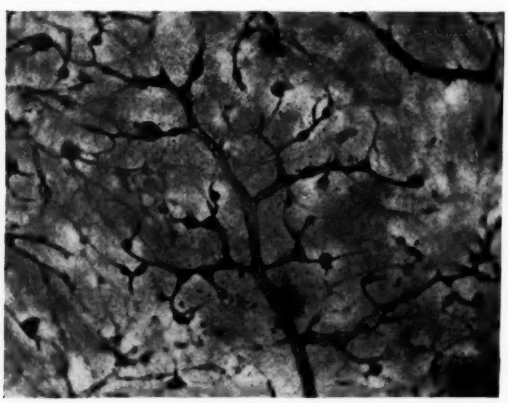

FIGURE 1

India ink injection of vascular tree showing myriad of microaneurysms.

DISEASES OF THE NAILS. Francesco Ronchese, M.D. In: *CURRENT THERAPY—1960.* Edited by Howard F. Conn. W. B. Saunders Co., Phil., 1960. P. 477.

External nail disorders include bacterial infections, fungal infections, and disorders from contact. Various medications are suggested for bacterial infections. Penicillin in ointment form is not to be used because of its sensitizing property. In regard to fungal infection it is reminded that a diagnosis cannot be made by sight and it is highly improper to prescribe griseofulvin unless pathogenic fungi have been found under the microscope on direct examination and cultures.

The difficulty in treating periungual warts is discussed.

Disorders of the nails of internal or systemic origin are psoriasis, fragility, clubbing, and others. Psoriasis of the nails is a very common disorder. Sometimes the nails return to normal for unknown reasons. Often a diagnosis by sight, viz., without laboratory investigation, of "fungus" of a psoriatic nail is followed by uncalled-for expensive local and internal therapy or for useless gruesome surgical avulsion.

CARCINOMA IN SITU OF THE UTERINE CERVIX. Herbert Fanger, and Thomas H. Murphy. Surg. Gynec. & Obst. 111:177, 1960.

Histologic and topographic studies have been made on fifty-two cone biopsies of the cervix containing carcinoma *in situ* and eleven cases of atypical hyperplasia. Carcinoma *in situ* occurred predominantly in the external cervical os and adjacent endocervix. Frequently, the tumor grew as a continuous sheet over large areas of the endocervix. However, in a significant number of cases, the tumor was limited to small foci so that cone biopsy was deemed preferable to punch biopsy because the larger sample of tissue more likely would demonstrate the lesion.

Hysterectomies revealed residual carcinoma *in situ* in five of twenty-two cases included in the topographic survey and in seventeen other cases. This observation demonstrates the necessity of hysterectomy or careful cytologic follow-up whenever a cone biopsy has revealed intraepithelial carcinoma.

Stromal invasion was infrequently demonstrated. There were two rare cases of carcinoma *in situ* with

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lymphatic invasion. In one, the lymphatic permeation was unusually extensive and there were metastases to regional lymph nodes.

TUBERCULOSIS SPONDYLITIS. A. A. Savastano and John G. Pierik. Am. J. Orth. 2:215, 1960.

It is observed that tuberculous spondylitis involving bones and joints has become uncommon. The reasons for this are numerous and well known. However, the orthopedic surgeon of today may still encounter an occasional case of tuberculosis which demands his skill and knowledge for successful treatment and a satisfactory functional result. The basic general principles of therapy have been dramatically altered since the introduction of the antituberculosis chemotherapeutic agents, which in turn have made possible direct, definite surgery in so many cases.

The authors present a single case study of a patient with tuberculous spondylitis which presented a diagnostic problem. A review of the combined chemotherapy and surgical intervention leading to a successful outcome is presented.

It is pointed out that chemotherapy has been dramatic in its effect and has made direct surgical intervention possible in cases where surgical treatment could not be offered prior to the days of antituberculous chemotherapy. The isonicotinic acid hydrazides, and particularly iproniazid (Marsilid) are at present the drugs of choice in treatment. Biopsy of suspected lesions should be done early and is frequently important for diagnosis. Anterior body fusion in Pott's disease is now considered a safe and successful procedure.

FATAL MYOCARDIAL INFARCTION IN PREMENOPAUSAL WOMEN. Report of Autopsied Cases. George F. Meissner and Daniel Moore, Jr. Lab. Invest. 9:142, 1960.

Myocardial infarction in premenopausal women without associated factors is almost unknown. In most instances, diabetes or hypertension is present, conditions which tend to increase the incidence of myocardial infarction in older women and in men in general. A case of acute myocardial infarction, found at autopsy of a twenty-three-year-old white woman, is described, which was associated with familial hypercholesterolemia. A review of autopsied cases from the literature and of eight additional cases from the files of the Rhode Island Hospital indicated strikingly the rarity of this condition, particularly in the absence of associated pathology. This appears to be the largest series of cases reported of fatal myocardial infarction, verified by autopsy, in premenopausal women. In men of comparable age (under 49) who had no associated pathology fatal myocardial infarction has been found to be more frequent than in women; but even in young men, as in premenopausal women, the incidence of myocardial infarction is far greater when there are associated diseases.

LE UNGHIE NEL LICHEN PLANUS (The Nail in Lichen Planus). Francesco Ronchese. Atti Soc. Ital. D.e S.e Sez. 34:715, 1959. Reg. Suppl. # 12, Minerva Dermat. v. 34, 1959.

In the majority of cases of lichen planus of Wilson no ungual changes are observed. However, in about 2 per cent of the cases, there are abnormalities such as longitudinal ridges, more or less deep fissures and thinning of the nail plate. Future investigation, including histologic studies, may indicate whether or not there is an ungual lichen planus analogous to ungual psoriasis.

SERUM LIPIDS AND ARTERIOSCLEROSIS IN PROSTATIC CANCER PATIENTS. George F. Meissner and Constance C. Moehring. Circulation 22:788, 1960.

In order to test the hypothesis that castration and estrogen therapy in men leads to serum lipid changes accompanied by amelioration of arteriosclerosis, serum lipids were determined periodically in 163 patients with prostatic carcinoma. These were treated for periods of four months to two and one-half years by orchiectomy and estrogens, which generally resulted in gynecomastia. Twelve of these patients have come to autopsy. Their coronary arteries and aortas were evaluated grossly for the degree of arteriosclerosis and particular attention was paid microscopically to the presence or absence of "early and active" lesions. The gross specimens are being saved for a simultaneous final grading at the conclusion of the study.

To date, it would appear, that there were only slight serum lipid changes and that there was no definite correlation between these and arteriosclerosis found at autopsy, which could be considered a result of castration or estrogen therapy. A series of ten untreated prostatic cancer patients found at autopsy during the same period of time showed no significant difference as to the degree of arteriosclerosis, when compared to the treated cases.

MEDICAL EDUCATION IN COMMUNITY HOSPITALS. Alex M. Burgess, Sr. Ann. Int. Med. 52:1363, 1960.

Community hospitals in the United States care for more than seventy-five per cent of the patients who suffer from acute medical or surgical condi-

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tions. About half of them offer approved intern and/or resident training. Most of the physicians appointed to their house staffs are graduates of medical schools outside the U.S.A. and Canada. Some of these foreign graduates have shown evidence of poor basic medical education but many are able and well-educated physicians.

Screening by the Educational Council for Foreign Medical Graduates will protect American patients from being cared for by poorly trained doctors in any of our hospitals and it is to be hoped that enough foreign physicians will wish to come to this country so that the experience which they seek can be afforded to them and good programs of education can be maintained with the resulting improvement in patient care and staff education. Of the sixty-two community hospitals in New England which support approved programs more than half have appointed directors of Medical Education, either half- or full-time.

CERVICAL PREGNANCY WITH MISSED ABORTION. Report of a Case. Stanley D. Davies and Paul E. Barber. Obst. & Gynec. 15:439, 1960.

Until 1945, when Studdiford made a survey of the world literature, cervical pregnancy was not recognized as a definite clinical entity by most American textbooks of obstetrics. Since then, many reports have appeared in the literature. Schneider and Dreizin made a very comprehensive and critical review of the world literature on this subject in 1957. They accepted only seventeen of the sixty cases reported as true cervical pregnancy.

The authors in this report present a case of a forty-three-year-old housewife who was admitted to the hospital for a routine curettage for menometrorrhagia. At the time of the curettage, a profuse hemorrhage was encountered which required a total abdominal hysterectomy to control the bleeding. The pathological report proved the case to be one of cervical pregnancy with the placentation limited to the region of the endocervical canal. A colored photograph of the gross specimen and photomicrographs of the chorionic villi in the region of endocervical glands were submitted to prove the diagnosis.

From the history this case was classed as a missed abortion of a true cervical pregnancy because more than two months had elapsed between the initial hemorrhage and the attempted curettage. Other conditions that supported the diagnosis of a missed abortion were: (1) a regressing corpus luteum of the ovary, (2) degenerating chorionic villi in the endocervix, (3) a closed cervix, (4) failure of the cervix to increase in size during the period of observation, and (5) absence of decidua in the uterus. To the best of the authors' knowledge, this is the first case of missed abortion of a true cervical pregnancy to be reported in the American literature.

PSEUDOPELADE. Francesco Ronchese. A.M.A. Arch. Dermat. 82:336, 1960.

Loss of hair with a distinct clinical pattern and with histopathology which was not pathognomonic was described by Brocq in 1885 under the name of pseudopelade. Its etiology still remains obscure. Recent studies suggested that lichen planus of the scalp could be the cause of the alopecia. To date there is insufficient evidence that any disease, external or systemic, is the cause of pseudopelade. Lichen planus is particularly doubtful because of its rarity on the scalp. The term pseudopelade, limited to the loss of hair with a pattern of alopecia areata and with unknown etiology, should remain because it has been in use for seventy-odd years and cannot be replaced by a satisfactory English term. The term alopecia cicatrisata should not be used as a synonym of pseudopelade, but should be limited to loss of hair of known etiology, such as, for example, that from chronic discoid lupus erythematosus, sarcoidosis, or metastases to the scalp from internal cancer.

ARTERIAL EMBOLECTOMY. Seebert J. Goldowsky and J. Robert Bowen. J.A.M.A. 172:799, 1960.

This study deals with the results of arterial embolectomy performed over an eleven-year period ending January 1, 1959. The presentation of 100 per cent follow-up is a unique feature of this work since other studies fail to consider this aspect of the subject.

Forty-six operations in forty-two patients, ranging in age from thirty-eight to eighty-two years, were encountered. All but one of the operations was performed at the Rhode Island Hospital, and thirteen embolectomies on twelve patients were done by the senior author. Twenty-six of the total group had auricular fibrillation, and fourteen patients with an average age of 53.8 years had rheumatic heart disease. The others had an average age of 66.5 years.

In thirty-five of the forty-two patients, the heart was presumably the source of the embolus. In the remaining seven cases, no source of origin of the emboli was found. Five of these cases were autopsied.

Twelve surviving cases were placed on long-term anticoagulant therapy. Results in this group of cases were good since no case developed a major

embolus while under adequate control. One of these patients died of a massive retroperitoneal hemorrhage after sympathectomy.

Operative mortality (hospital deaths) was 37 per cent. Among the survivors, limb salvage was 100 per cent; 27.3% of patients still survive who were operated on two years or more prior to the closing date of this study.

Mortality was not significantly altered in this series with respect to whether the operation was performed before, or after eight hours had elapsed from, the onset of symptoms. Nevertheless, delay in instituting surgery must influence survival and limb salvage.

TRAUMATIC COMPRESSION FRACTURES OF THE DORSOLUMBAR PORTION OF THE SPINE. A. A. Savastano and John G. Pierik. J. Internat. Coll. Surgeons 34:93, 1960.

This is a study of 159 cases of stable traumatic compression fractures, in which the patients were admitted to the Rhode Island Hospital in Providence, from 1953 to 1959. Of the 159 cases, forty were reappraised two to seven years after the initial trauma.

A breakdown of the total number of patients admitted is made as to age, sex, nature of injury, vertebral body involved, symptoms and signs presented and form of treatment used. In forty cases a comparison of the results obtained is made between a group treated by reduction and immobilization (nonfunctional type of treatment), and another group treated by no reduction, no support or minimal support (functional type of treatment).

Patients treated by the functional method remained in the hospital for a shorter period than did those treated by the nonfunctional method. Patients treated by the functional method returned to work sooner than did those treated by the nonfunctional method. In a large number of patients treated by the reduction-immobilization method the compressed fractured vertebra settled to the position of original impaction two to seven years after the original injury. The majority of the patients returned to their former occupations regardless of the type of treatment chosen. In the lumbar portion of the spine, the first lumbar vertebra was injured most frequently, while in the dorsal segment the twelfth dorsal vertebra was the one most commonly injured.

MEDICAL EDUCATION AND PRACTICE IN ISRAEL. Alex M. Burgess, Sr. New England J. Med. 263:283, 1960.

The State of Israel with a population of two million, more than half of which is made up of immigrants from all over the world, has faced and successfully solved the question of how to deal with the medical care of this great influx of people and at the same time keep medical standards at a high level and medical education continuously progressing. In a two weeks' visit in connection with a staff exchange between Poriah Hospital, Tiberias and Miriam Hospital, Providence, the writer was privileged to obtain an over-all view of medical education and practice. This can be outlined as follows:

Undergraduate medical education is conducted at the Hebrew University–Hadassah Medical School which has a distinguished faculty and, with the completion of the new medical center about three and a half miles from the center of Jerusalem, will be housed in one of the finest set of buildings to be found anywhere. Graduate education is carried on in the government hospitals and those of the Kupat Holim, the sick fund of the General Federation of Labor, and, of course, in the hospital of the University. The hospitals are manned by highly selected experts in the various specialties. The large number of immigrant physicians who came to the country with their countrymen are practicing among the people with whom they came and are manning the clinics of the Kupat Holim. Great efforts are being made to provide post-graduate education for these physicians. As some of them are not basically well trained, the arrangement whereby their work is mostly in out-patient clinics, while serious disease is dealt with by experts in the hospitals, results in a generally high grade of patient care throughout Israel.

CONTACT DERMATITIS FROM CINNAMON. Arthur B. Kern. A.M.A. Arch. Dermat. 81:599, 1960.

Since the first published report of contact dermatitis from cinnamon in 1897 there have been only occasional reports of dermatitis from it or from cassia, which is often used as its substitute. The volatile oils of these substances, both plant extracts, contain as their chief ingredient a powerful irritant, cinnamic aldehyde. Although these oils are present in very small amounts in cinnamon powder employed by bakers and confectioners, they nevertheless pose a definite risk.

A candy factory worker was seen because of a typical contact dermatitis involving hands, abdomen, and thighs. For two weeks prior to the onset of the eruption his job had involved carrying heavy batches of candy used in the production of "cinnamon hearts." Because of its weight, he would frequently support the mass of candy on his upper thighs and abdomen. Patch testing revealed a weak reaction to oil of cinnamon leaves and a very strong reaction to cinnamic aldehyde, both ingredients of

concluded on next page

the cassia flavor in the "hearts."

Reactions to cinnamon and cassia are relatively uncommon but they must be kept in mind as possible causes of contact dermatitis, particularly in bakers and confectioners.

DERMATOFIBROSARCOMA PROTUBERANS. Review of the Literature and Report of Four Cases. Bencel L. Schiff, Mauray J. Tye, Arthur B. Kern, Giuseppe Moretti and Francesco Ronchese. Am. J. Surg. 99:301, 1960.

The French dermatologists, Darier and Ferrand, described this entity first in 1924. The diagnostically most important feature, the potato-like appearance of the tumor, is shown in the illustration reproduced from Darier and Ferrand's paper.

The origin of the tumor is still uncertain. Considerable controversy exists in regard to the histopathology. The most important feature remains its non-specificity. The clinical appearance remains the most important diagnostic feature. The tumor is locally malignant. It recurs if incompletely removed. Metastases have been reported in a few cases, but without autopsies.

Four cases of this disorder are reported and the literature extensively reviewed.

JOE—THEN AND NOW. Laurence A. Senseman. Listen 13:10, July-Aug. 1960; *DICK—ASKING FOR THE WORST.* Laurence A. Senseman. Listen 13:14, Sept.-Oct. 1960; *AUNT BESS—DEFICIENT IN VITAMIN B.* Laurence A. Senseman. Listen 13:14, Nov.-Dec. 1960.

A series of three articles appeared in LISTEN magazine, a magazine published in the interest of scientific education for the prevention of alcoholism. These three articles were the first of a series of five articles on the effects of alcoholism on the central nervous system.

Joe—Then and Now is a story of a patient who had been drinking over a long period of time. He was rarely every drunk but his continuous drinking had impaired his judgment, wrecked his marriage and destroyed his business. He was an intelligent, well-educated man who had been ruined intellectually by alcohol, a not uncommon occurrence seen today in those who drink persistently.

Asking for the Worst is the second article in the LISTEN series of case studies in which "Dick" was injured in an automobile accident while driving under the influence of alcohol. He developed a subdural hematoma that was not recognized until the following day. Intracranial bleeding is enhanced by a prolonged bleeding time in the alcoholic and a fatal hemorrhage may occur. Alcohol is responsible for the high rate of automobile accidents resulting in death.

The third article deals with a patient "Aunt Bess" with a polyneuritis due to Vitamin B deficiency. This was the result of prolonged bouts of drinking without a proper diet. Her eventual death was due to vitamin deficiency and other complications.

Two more of this series of articles will appear in 1961.

ABSTRACTS SOUGHT

The editors invite Rhode Island physicians who have papers published in other journals to submit abstracts of such papers, not to exceed two hundred (200) typed words, for publication in the RHODE ISLAND MEDICAL JOURNAL.

Check . . .

MAY 2 and 3, 1961

150th MEETING

Rhode Island Medical Society

MILK COMMISSION REPORT — PROVIDENCE MEDICAL ASSOCIATION, 1960

CERTIFIED MILK in Providence during 1960 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Hampshire Hills Farm, Wilton, N. H.; Hillside Farm, Cranston, R. I.

Through the courtesy and co-operation of the Boston Commission we have accepted their certification of one farm from Massachusetts and one from New Hampshire.

All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections.

The Commission, six years ago, discontinued the sale of Raw Certified Milk in the Providence market to conform with the standards in most of the larger cities. The legal standard for Pasteurized Certified milk is still 500 colonies per ml. and the actual count on all samples examined by this Commission the past year was 208 colonies per ml.

Vitamin D Certified Milk is defined as whole Certified Milk rendered antirachitic by irradiation or by the addition of a concentrate and shall be of sufficient vitamin potency to show, by biological assay, a content of at least 400 U.S.P. units per quart.

The Wisconsin Alumni Research Foundation of Madison, Wisconsin, has been doing the assaying of Vitamin D from Hillside Farm and the results have been entirely satisfactory. For the coming year we shall accept the report of this test from the State Milk Inspector.

Certified Fat-free (Skim) Milk, containing not more than 0.05 per cent butter fat, and with Vitamin A added has conformed to the standards set by the American Association of Medical Milk Commissions.

During the past year the analysis of milk samples has been performed in the laboratory of the Milk Department of Providence, which is located at the Charles V. Chapin Hospital. Doctor Joseph Smith, the Milk Inspector, and his assistant, Mr. Richard S. McKenzie, have been most co-operative in doing this work for the Milk Commission.

During the summer months there was found a noticeable increase in Coliform bacteria in the pasteurized milk supply of greater Providence area. In all the Certified samples tested this past year, only six (6) samples had Coliform colony count above 10 per ml.

The Sanitary Inspector is appointed by the Commission to supervise the sanitary conditions at the farm and the physician is responsible for the health of the employees at the farm. Both of the men are licensed practitioners. The Veterinarian to the farm is also appointed by the Commission.

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MONTHLY AVERAGES OF CERTIFIED MILK FOR 1960

	CHERRY HILL H. P. HOOD			HAMPSHIRE HILLS						HILLSIDE FARM					
	Pasteurized			Pasteurized			Skimmed with Vit. A & D			Pasteurized			Skimmed with Vit. A & D		
	B.F.	T.S.	Bac.-teria per C.C.	B.F.	T.S.	Bac.-teria per C.C.	B.F.	T.S.	Bac-teria per C.C.	B.F.	T.S.	Bac.-teria per C.C.	B.F.	T.S.	Bac-teria per C.C.
January	4.2	13.00	17	4.7	13.91	770	.36	8.92	650	4.2	13.07	25	.....	.....	.....
February	4.3	13.26	55	4.7	14.14	55	.02	8.89	470	4.2	13.07	17	.....	.....	.....
March	.....	.....	.....	4.6	13.72	726	.....	.....	.....	4.2	13.12	171	.....	.....	.....
April	.....	.....	.....	4.7	14.01	630	.....	.....	.....	3.9	12.72	125	.....	.....	.....
May	.....	.....	.....	4.7	13.97	810	.....	.....	.....	4.0	12.67	38	.....	.....	.....
June	4.1	12.90	107	4.7	13.94	906	.....	.....	.....	4.0	12.80	122	.....	.....	.....
July	4.0	12.86	35	4.6	13.80	582	.....	.....	.....	3.9	12.63	230	.....	.....	.....
August	4.1	12.85	20	4.7	13.78	290	.05	8.80	242	4.1	12.66	115	.....	.....	.....
September	4.1	12.84	84	4.7	13.73	335	.18	8.84	30	4.0	12.67	101	.....	.....	.....
October	4.1	12.94	65	5.2	14.68	140	.....	.....	115	4.1	12.95	66	.....	.....	.....
November	4.2	13.09	44	5.0	14.43	965	.....	.....	60	4.1	12.92	100	.01	8.91	90
December	4.0	12.70	25	.....	.....	.....	.....	.....	.....	3.8	12.82	20	.01	8.91	56
Yearly Average	4.1	12.93	50	4.7	14.01	564	.15	8.86	261	4.0	12.84	94	.01	8.91	73

ON THE MEDICAL LIBRARY BOOKSHELVES

The Editor acknowledges the receipt of the following books and thanks the publishers for sending them. Unfortunately, not every volume received is reviewed either because of lack of space or because the person to whom the book is assigned fails us. Whether reviewed or not, the books are appreciated and are available at the Library.

THE TREATMENT OF BURNS by Curtis P. Artz, M.D. and Eric Reiss, M.D. W. B. Saunders Co., Phil., 1957. $7.50.

A COOKBOOK FOR DIABETICS. Recipes from the ADA FORECAST by Maude Behrman. Edited by Leonard Louis Levinson. American Diabetes Association, Inc., N. Y., 1959. $1.00 from 1-9 copies; less for larger numbers.

LOVE, SKILL AND MYSTERY by Theodor Bovet. Doubleday & Co., Inc., Garden City, N. Y., 1958. $3.50.

OBSERVATIONS ON DIRECT ANALYSIS. The Therapeutic Technique of Dr. John N. Rosen by Morris W. Brody, M.D. Vantage Press, N. Y. $2.95.

CIBA FOUNDATION SYMPOSIUM ON THE KIDNEY arranged jointly with the Renal Association. Editor of the Renal Association, A. A. G. Lewis. Editor for the Ciba Foundation, G. E. W. Wolstenholme assisted by Joan Etherington. Little, Brown & Co., Bost., 1954. $6.00.

CHRONIC ILLNESS IN THE UNITED STATES. Vol. II. Care of the Long-term Patient. Commission on Chronic Illness. Published for the Commonwealth Fund by Harvard University Press, Cambridge, 1956. $8.50.

INTRODUCTION TO ANESTHESIA. The Principles of Safe Practice by Robert D. Dripps, M.D., James E. Eckenhoff, M.D. & Leroy D. Vandam, M.D. W. B. Saunders Co., Phil., 1957. $4.75.

THE OFFICE ASSISTANT IN MEDICAL OR DENTAL PRACTICE by Portia M. Frederick & Carol Towner. W. B. Saunders Co., Phil., 1956. $4.75.

DISEASES OF THE BREAST by C. D. Haagensen, M.D. W. B. Saunders Co., Phil., 1956. $16.00.

TABULATING EQUIPMENT AND ARMY MEDICAL STATISTICS by Albert G. Love, Eugene L. Hamilton & Ida L. Hellman. Office of the Surgeon General, Department of the Army. Wash., 1958. $2.00.

COLD INJURY, GROUND TYPE IN WORLD WAR II by Colonel Tom F. Whayne & Michael E. DeBakey. Medical Department, United States Army. Office of the Surgeon General, Wash., 1958. $6.25.

PREVENTIVE MEDICINE IN WORLD WAR II. Vol. IV. Communicable Diseases Transmitted Chiefly through Respiratory and Alimentary Tracts. Medical Department, United States Army. Office of the Surgeon General, Wash., 1958. $5.50.

SURGERY IN WORLD WAR II. General Surgery. Medical Department, United States Army. Office of the Surgeon General, Wash., 1955. $4.25.

SURGERY IN WORLD WAR II. Orthopedic Surgery in the European Theater of Operations. Medical Department, United States Army. Office of the Surgeon General, Wash., 1956. $4.00.

501 QUESTIONS AND ANSWERS IN ANATOMY by Stanley D. Miroyiannis. With an introduction by Ernest V. Enzmann. Vantage Press, N. Y., 1959. $5.00.

MEDICAL ELECTRICAL EQUIPMENT. Principles, Installation, Operation and Maintenance of Electrical Equipment used in Hospitals and Clinics. Advisory Editor: Robert E. Molloy. Philosophical Library, Inc., N. Y., 1958. $15.00.

MODERN CLINICAL PSYCHIATRY by Arthur P. Noyes, M.D. & Lawrence C. Kolb, M.D. 5th ed. W. B. Saunders Co., Phil., 1958. $8.00.

I PRESCRIBE LAUGHTER by Thomas Richard Rees. Vantage Press, Inc., N. Y., 1960. $2.75.

THE POWER OF SEXUAL SURRENDER by Marie N. Robinson, M.D. Doubleday & Co., Inc., Garden City, N. Y., 1959. $4.50.

SCHIZOPHRENIA by Manfred Sakel, M.D. Philosophical Library, Inc., N. Y., 1958. $5.00.

CURRENT MEDICAL REFERENCES. Edited by Paul J. Sanazaro, M.D. Lange Medical Publications, Los Altos, Calif., 1959. $3.50.

DOCTOR STRAND by Boris Sokoloff, M.D. Vantage Press, Inc., N. Y., 1960. $3.50.

A PRACTICAL GUIDE FOR GENERAL SURGICAL MANAGEMENT by Julian A. Sterling, M.D. Vantage Press, Inc., N. Y., 1960. $3.00.

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BOOK REVIEWS

FUNDAMENTALS OF CHEST ROENTGENOLOGY. By Benjamin Felson, M.D. W. B. Saunders Company, Phil., 1960. $10.00.

The old-fashioned vogue for subtitles has declined in recent years, but it might well be revived for this book. The subtitle could be—"with reference to the lung fields only." The chest contains many things besides lungs, but cardiac, vascular, gastrointestinal and bone structures are mentioned only as they may cause changes in the appearance of the lung fields. Cardiac roentgenology and particularly angiocardiography is a large enough subject by itself to warrant books in its own right. In spite of the restrictions it takes 300 pages to cover the subject of the lungs alone.

The word "Fundamentals" is used in the title and fundamentals of interpretation are stressed throughout. Details of technique are absent or merely mentioned in passing. Don't look here for "How to Do" a bronchogram. Interpretation, however, is exhaustively covered; particularly in terms of general pathological conditions rather than specific etiological diagnoses. The inclusion of 450 illustrations in 300 pages gives a good indication of the supplementing of text with illustrative examples. The cuts are excellent, and actually show what the caption says they show (not all published cuts do, you know).

In the introduction, the author says that the book is intended for cover-to-cover reading and subsequently as an unobtrusive consultant. If by unobtrusive, he means to imply surreptitious, I would disagree. Neither the author nor the reader should be embarrassed to have the book used freely. Any physician,—surgeon, internist, bronchoscopist or roentgenologist—interested in pulmonary conditions could profit by owning and reading this book.

A bibliography of 326 references provide sources for further study, if desired. Numbered references are scattered through the test.

It is my misfortune that reviewers are not given the books that they review. I've just got to go out and buy this one for my office library.

PHILIP BATCHELDER, M.D.

CLINICAL MANAGEMENT OF BEHAVIOR DISORDERS IN CHILDREN by Harry Bakwin, M.D., and Ruth Morris Bakwin, M.D. 2d ed. W. B. Saunders Co., Phil., 1960. $11.00.

While the text of this book may tend to indicate to the reader a limited area of interest nothing could be further from the authors' intent and accomplishment.

There are twelve parts in this second edition, each with concise descriptions of the problems discussed and up-to-date references. These twelve sections include growth and development, psychologic care, care of the physically ill and handicapped child, etiologic factors, diagnosis and treatment of behavior disorders in children, problems related to mental functioning, abnormalities, emotional development, habit and training, organic illness and antisocial behavior. Specific syndromes like schizophrenia, infantile autism and hysteria are presented.

It is the sections dealing with behavior disorders that are most enlightening. In these areas the authors excel in clinical description and definitive modes of therapy. In areas relating to mental function where our knowledge is still limited the authors are more objective. The problems of the grade school child, the child with special talents, with superior intelligence, with inferior intelligence and disturbances in speech, difficulties in reading, writing and arithmetic and eneuresis are comprehensively documented with multiple authoritative opinions, each very well taken, but leave the reader in midstream without a solution to the problem. For this reason, particularly where sundry solutions and sundry authors are quoted, the information is less helpful.

The text is a must addition for any professional treating children. This is especially true now that organic disease is being conquered and we have more time to devote to the psychological problems of childhood.

BETTY BURKHARDT MATHIEU, M.D.

ON THE MEDICAL LIBRARY BOOKSHELVES

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THE PLASMA PROTEINS. Clinical significance by Paul G. Weil, M.D. Repr. from Amer. Pract. & Digest Treat., Sept. 1958. J. B. Lippincott Co., Phil., 1959. $3.50.

THE SEDIMENTATION RATE OF HUMAN EYTHROCYTES. Its Basic Concepts by Frank Wright, M.D. Vantage Press, Inc., N.Y., 1958.

The RHODE ISLAND MEDICAL JOURNAL

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TREATMENT OF RESPIRATORY DISTRESS OF THE NEWBORN WITH HUMAN FIBRINOLYSIN*

(A Preliminary Report)

HERBERT EBNER, M.D.; GERALD SOLOMONS, M.D., AND H. J. MACMILLAN, M.D.

The Authors. *Herbert Ebner, M.D., Chief, Department of Anesthesia; Gerald Solomons, M.D., Assistant Pediatrician; H. J. MacMillan, M.D., Staff Anesthetist, Providence Lying-In Hospital.*

IT IS ESTIMATED that 25,000 deaths are caused by hyaline membrane disease each year in the United States.[1] This condition is most prevalent among premature infants, those delivered by Caesarean section, and those born of diabetic mothers. It does, however, also occur in term infants, but hyaline membranes have not been demonstrated in the stillborn. Clinically, the most characteristic feature is a gradual onset of respiratory embarrassment. The infant may or may not be apneic at birth, but most frequently, on cursory examination, the respiratory response does not seem unusual. Within a matter of minutes, or at most hours, the clinical picture becomes well defined; it is one of progressive lower respiratory tract obstruction. The infant exhibits subcostal, and then intercostal retraction; the alae nasi are active; and the dyspneic newborn works desperately to ventilate its lungs. In rapid sequence it undergoes "cyanotic spells," which consist of apneic periods of a minute or more. Eventually, one of these attacks proves fatal, and the infant usually dies within twelve to forty-eight hours after birth. At some stage of the disease process, a typical reticulo-granular pattern of increased density has been described in the lung fields by X ray.[2] At autopsy, the lungs are found to be bulky, and have the consistency of liver. Microscopy reveals areas of atelectasis with intense congestion of the pulmonary capillaries. The alveoli are lined with an eosinophilic condensed transudate, the hyaline membrane.

From the departments of Anesthesiology and Pediatrics, Providence Lying-In Hospital.

*This work was supported in part by a grant from the Wyeth Laboratories, Inc. The fibrinolysin used in this study was supplied as Actase Fibrinolysin (human) by the Ortho Pharmaceutical Corporation, Raritan, New Jersey.

Many theories have been advanced to explain the presence of the hyaline membrane, and a great deal of investigation has been done on the subject. It is not pertinent to this discussion to elaborate on them, but from these investigations certain incontrovertible facts emerge. First, Gitlin and Craig[3] using fluorescent labeled antibody studies, have demonstrated that the membrane has a basic fibrin composition that resembles blood clot. Second, altered pulmonary hemodynamics at birth are responsible for the transudation of fibrinogen across the capillary wall. This fibrinogen is a product of the infant's own capillary transudate from alveolar-capillary leakage. It is acted on by thromboplastin and converted into fibrin. This fibrin is deposited in the alveoli. Third, in some infants, due to a deficiency of fibrinolytic enzymes, this fibrin is not liquefied and removed, and the end result is hyaline membrane formation.[1] This is of course an over-simplification of a complex process, but suffices for the purpose of this discussion. There are several prominent investigators who believe that the hyaline membranes are not related to the respiratory distress. Gruenwald[4] believes that the primary disorder is atelectasis, and that the membranes are "eosinophilic red herrings." Craig[5] in a series of brilliant *in vitro* experiments has, however, demonstrated that these membranes are primarily in those alveoli which are connected with the terminal bronchioles, and that they do not appear in the atelectatic areas. They must act in part as a definite barrier to the ventilation of the more peripheral alveoli, as well as interfere with diffusion of oxygen and carbon dioxide within the air-containing proximal alveoli which still communicate freely with the bronchi. This dovetails with the clinical picture of lower respiratory tract obstruction seen in this syndrome. Having established the composition and importance of the membranes, Craig[6] demonstrated that fibrinolysin induced into the lung of a premature infant who died with hyaline membrane disease caused dissolution of the hyaline membrane *in vitro*. These experiments

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suggested a method of treatment for infants with the so-called respiratory distress syndrome.

Methods and Materials

Prior to our use of human fibrinolysin in infants, a series of guinea pig experiments was performed. These are to be reported in greater detail elsewhere. It is a fact that certain experimental animals subjected to high oxygen concentrations demonstrate the pathologic pulmonary conditions of edema, atelectasis, and hyaline membrane formation which closely resemble the respiratory distress syndrome of the newborn. Accordingly, sixty-three guinea pigs (Fig. 2) averaging 350 grams, were exposed to 85 per cent to 90 per cent oxygen for from 60 to

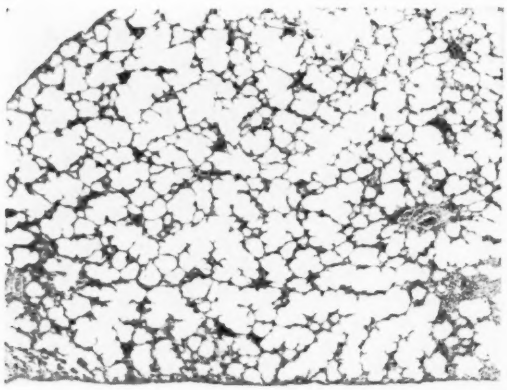

FIGURE 2
Normal Guinea Pig lung. X 50

82 hours. These animals uniformly became seriously dyspneic in forty hours, developed hyperpnea, with alternate periods of apnea by fifty hours, and finally expired in sixty to eighty-two hours. At autopsy, pulmonary edema with congestion and increased lung weights was demonstrated, and histologically there was a mixture of edema, congestion and hyaline membrane formation (Figs. 3, 4, 5). Twenty-four animals were thus treated and sacrificed at various intervals to study the course of oxygen toxicity. Thirty-four animals were subjected to an hyperoxic atmosphere, and prior to the last stages of the disease, given nebulized human fibrinolysin (Actase)® into the closed treatment chambers. Four of these died within two hours of the beginning of the treatment; the remainder were sacrificed at various stages of the disease and the recovery period. The Actase® solution was diluted to contain 50,000 units per 200 ml. of distilled water. This was delivered into the nebulizer over a two- to six-hour period. It seems significant that none of the guinea pigs so treated died spontaneously with the disease, except in four cases where there was insufficient time to complete the Actase® treatment.

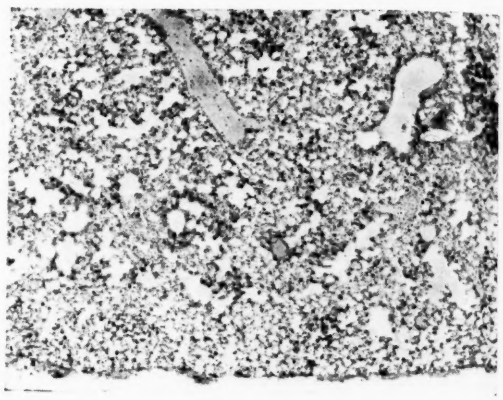

FIGURE 3
Guinea Pig lung after 60 hours of oxygen poisoning. There is edema, congestion and early hyaline like membrane formation.

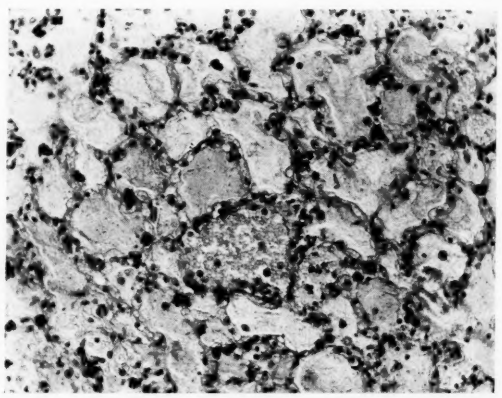

FIGURE 4
Guinea Pig lung after 70 hours of oxygen poisoning. There is marked pulmonary edema; the alveoli being filled with the transudate from the alveolar capillaries many of which have swollen and ruptured the membranes. There is hemorrhage into many alveoli and marked congestion of the alveolar capillaries. The pigment particles are india ink particles which were mixed with the amniotic fluid aspirate prior to oxygen poisoning. X 200

Four animals were used as untreated controls (A, Fig. 1); four were given excessive dosage with nebulized Actase® and showed no untoward effect (Fig. 6). A fair indication of the success of the treatment used is also indicated by a tabulation of the autopsied lung weights of the animals (Fig. 1). The average lung weight of the animal suffering from oxygen poisoning increased with the duration of the disease up to eighty-two hours, at which time all pigs died without treatment. The animals treated with Actase® actually have lungs that weigh more (are more edematous), but this is interpreted as progress of the disease beyond that of the untreated. With the Actase® therapy they are able to survive the oxygen poisoning, and show only residual

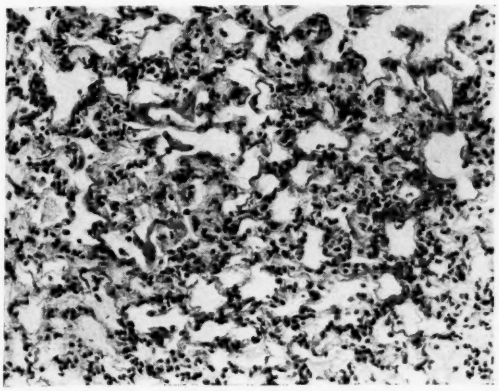

FIGURE 5

Guinea Pig lung after 80 hours of oxygen poisoning. Hyaline like membranes partially line many alveoli; there is moderate atelectasis throughout with thickening of the alveolar septae. X 150

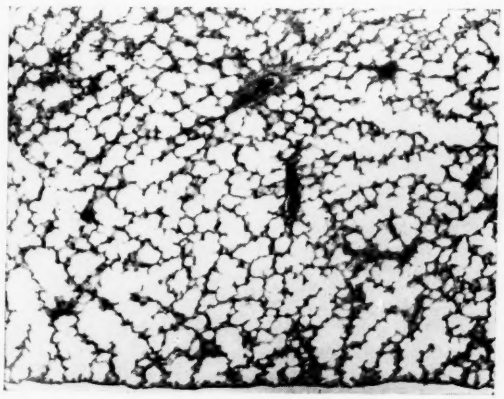

FIGURE 6

Guinea Pig lung treated with 100,000 F. U. of human fibrinolysin sacrificed 48 hours later showing minimal histologic changes as compared to normal untreated lung. X 50

effects of the disease, ten to eighteen days later (Figs. 7, 8, 9). A moderate amount of pulmonary congestion in the four animals treated with Actase® alone can be seen in the small increase in lung weights of these animals (B, Fig. 1). The principal features of the histologic examination were vascular congestion, atelectasis, membrane formation, edema, and pneumonia. No untoward effects of hemorrhage, proteolysis, or edema, which could be ascribed to the use of Actase® alone, was observed. On the other hand, the lungs of the diseased animals treated with Actase,® showed early increased aeration (Figs. 7, 8, 9). Hyaline membrane formation in the guinea pigs is not uniform; therefore it is difficult to state that there was complete and definite resorption of the membranes in this small series of animals. The increased weight of the lungs of Actase® treated animals was associated with the earlier development of patchy pneumonia. Again, this is interpreted as survival of the animals to a later stage in the natural life history of the disease. Four animals were given nebulized water (mist) as controls. It was concluded that Actase® was nontoxic for the experimental animals in the concentrations used.

Prior to using Actase® on infants suffering from respiratory distress, the following experiment was carried out to assess the toxicity of this drug on the human organism. Fifty newborns were scratch-tested with 1:100,000 dilution of fibrinolysin, in water, saline being used as a control. The tests were read after twenty minutes and twenty-four hours. In addition, five premature infants, all under five pounds in weight, were given intradermal injection of 0.1 cc of 1:100,000 dilution of fibrinolysin, with saline as a control. Readings were taken after twenty-four and ninety-six hours. All tests were completely negative and no evidence of allergic reaction to fibrinolysin was found in this series. Accordingly, Actase® was nebulized into the incubators of infants suffering with respiratory distress.

Case Reports

Case 1. A 4-lb., 2-oz. (1.87 kg.) male infant was born to a twenty-six-year-old gravida 3, para 2. After 55 minutes of tumultuous labor, during which she received 0.2 gm. of secobarbital sodium (Seconal®) and 25 mgm. of promazine (Sparine®), she received five minutes of cyclopropane anesthesia for delivery. The infant cried immediately but remained cyanotic. In the premature nursery the infant was treated with mistogen and oxygen, ascorbic acid, digitalis and vitamin K. X-ray examination at eighteen hours showed increased markings in both lungs which appeared to be due to disseminated atelectasis. A total of 100,000 units of Actase® was nebulized in air during the last twenty hours of life. In this case, inasmuch as there seemed to be excessive mucus production, 10,000 units of Actase® in 4 ml. saline was injected intratracheally during a five-minute period. Clinically,

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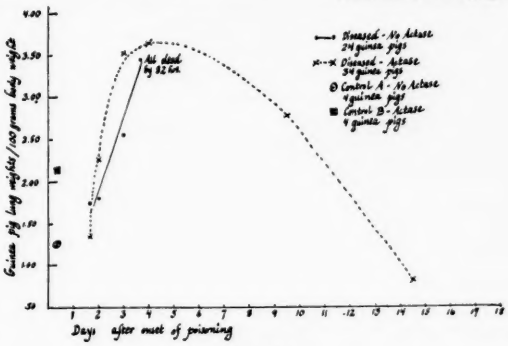

FIGURE 1

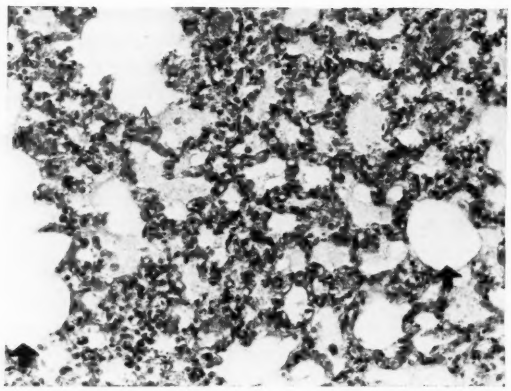

FIGURE 7

Guinea Pig lung with oxygen poisoning and early hyaline like membrane formation treated with human fibrinolysin nebulized into treatment chambers (50,000 F.U.). Shows beginning aeration of the lung, (note aerated terminal bronchioles — arrows).

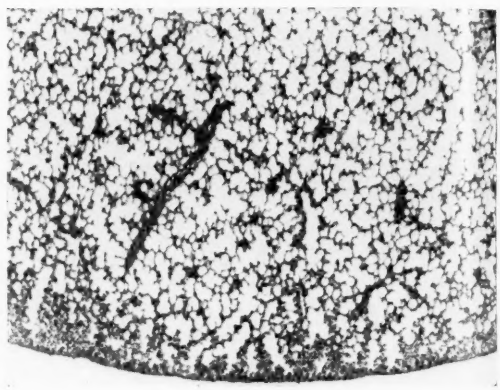

FIGURE 8

Guinea Pig lung after fibrinolysin treatment and recovery from the hyaline like membrane disease, eight days later showing almost completely cleared lung airway. X 50

the patient did not improve, but the serum potassium levels dropped from 8.5 mEq/1 at 18 hours to 5.3 mEq/1 twelve hours later and twelve hours before death. Autopsy examination of the lungs showed pulmonary congestion, and scattered atelectatic area, and prematurity (34½ weeks).

From this case, it was concluded that the Actase® has no untoward effect when nebulized into the lungs with air, or when injected directly intratracheally.

Case 2. An 8-lb., 11-oz. (3.93 kg.) male infant was born to a thirty-three-year-old gravida 3, para 2. There had been one episode of false labor six days previously. The mother was blood type A Rh negative, but without demonstrable Anti Rh titre. Although the dates were uncertain, the patient appeared to be at term at delivery. She was in labor a total of seven hours and seven minutes; analgesic medication was 0.3 gm. of secobarbital (Seconal®) and 175 mgm. of meperidine (Demerol®). Anesthesia was with approximately eight minutes of cyclopropane before delivery. The infant was quite cyanotic at birth. Resuscitation was performed with intermittent endotracheal oxygen insufflation for twenty-two minutes. The infant also received 0.2 mgm. of nalorphine (Nalline®) given intramuscularly, without any effect. Further medications consisted of 1,200,000 units of penicillin; 985 mgm. of streptomycin; 25 mgm. of ascorbic acid; and 1.0 mgm. of Synkamin.® The baby was kept in mistogen with oxygen concentrations of 30 per cent to 40 per cent. X-ray examination of the lungs at nine hours of life showed normal heart and poor aeration of both lungs with bilateral disseminated atelectasis. There was a suggestion of hyaline-like membrane disease in the right lower

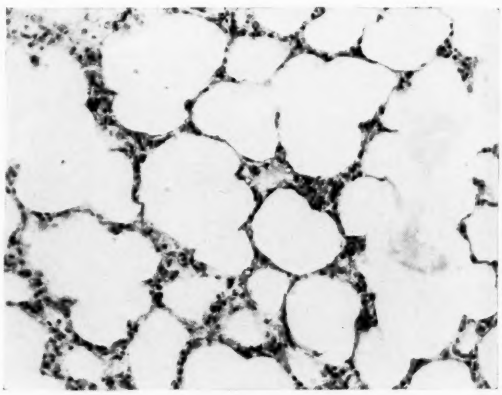

FIGURE 9

Guinea Pig lung almost completely cleared of hyaline like membrane disease with human fibrinolysin treatment at ten days after treatment. Only slight thickening of the alveoiar membrane remains. X 250

lobe. The first treatment was 50,000 units of Actase® in 200 ml. of sterile water nebulized by air into the semi-closed incubator over an eight-hour period. This was repeated at thirty hours of age, using 50,000 fibrinolytic units over a twelve-hour period. X rays taken at forty-eight hours of age showed improved aeration of both lungs with some degree of residual bilateral disseminated atelectasis. A third course of Actase® was given at seventy-two hours. X rays at this time revealed great improvement in the aeration of both lungs, which now appeared fully expanded and clear. The chest was essentially negative at three days of age. The infant was discharged from the hospital on the tenth day, weighing 8 lbs., 7 oz. (3.82 kg.). Subsequent development is said to be normal.

Case 3. A 5-lb. (2.26 kg.) female child was born to a nineteen-year-old primigravida after five hours of labor, during which she received 175 mgm. of meperidine (Demerol®), 1.07 mgm. of scopolamine and 0.3 gm. of secobarbital (Seconal®). She received saddle block anesthesia for the spontaneous delivery. The infant was 43 weeks gestation by dates. The fetal heart was 130 during labor, but dropped to 114, then to 84 just prior to delivery. The infant was apneic at birth. Resuscitation was accomplished by endotracheal insufflation with intermittent positive pressure oxygen for thirty-five minutes. X rays taken at this time showed a questionable reticulo-granular pattern suggestive of hyaline membrane disease. The infant made its first spontaneous respiratory effort at fifty minutes after delivery. This was followed by a feeble cry and the infant remained cyanotic. In the premature nursery, the child was treated with mist and oxygen in a semi-closed incubator and Actase® was added with air nebulization at the rate of 6,000 units per hour for twenty-eight hours continuously. There appeared to be rapid clinical improvement and X rays taken at this time bore out this impression. Additional therapy included streptomycin and ascorbic acid. The electrocardiogram was normal, except for slight right ventricular preponderance. The infant was sent home on the twenty-first day weighing 6 lbs. (2.72 kg.). Final X rays showed normal lung patterns.

Case 4. A 4-lb., 15-oz. (2.24 kg.) female infant was born to a twenty-nine-year-old gravida 7, para 2, by Caesarean section for abruptio placenta, at thirty-five weeks of gestation. She was given spinal anesthesia, and premedication of pentobarbital (Nembutal®) 0.1 gm. and scopolamine 0.43 mgm. She was Rh negative blood type without titre. The baby cried immediately but suffered secondary apnea for five minutes. There was prompt response to intermittent positive pressure oxygen in about thirty seconds. At two hours of age the infant began to manifest respiratory distress with an expiratory grunt and sternal retraction. Cyanosis was evident even in oxygen concentrations of 35 per cent to 40 per cent. X ray at six hours of age showed granular infiltration throughout both lung fields consistent with hyaline membrane disease. The heart and thymus were normal. Actase® treatment was started at seven hours of age using 25,000 fibrinolytic units dissolved in 200 cc of sterile water nebulized continuously with air into the incubator for the next eighty-eight hours of life. This totaled 400,000 units by the fourth day. X rays taken at the end of thirty-six hours of treatment still showed the granular appearance characteristic of hyaline membrane disease and also an increase in the heart size. Although the infant was markedly dyspneic at this time, improvement had been noted in the electrolytic pattern. At twenty hours of age the potassium was 7.0 mEq/1 and the sodium, 133 mEq/1, and at forty-eight hours of age, potassium was normal (5.0 mEq/1) and the sodium, 137 mEq/1. On the fifth day of life Actase® therapy was discontinued at which time the infant appeared much improved. X ray at this time showed normal aeration of the lungs. The electrocardiogram at forty hours showed prolonged Q T intervals and no evidence of hyperkalemia. The infant had a negative direct Coombs, but reached a high bilirubin of 13.2 mgm. per cent at the end of the first week of life. However, she continued to improve so that she was discharged weighing 5 lbs., 8 oz. (2.59 kg.) on the thirty-fourth day of life. Subsequent history showed that the infant was normal and without symptoms, except for a mild feeding problem.

Discussion

Until the basic physiologic aberrations are more thoroughly understood, treatment has of necessity been only supportive and for the most part empiric. The importance of early adequate ventilation of the newborn cannot be over-emphasized. Supplemental oxygen in concentrations of 25 per cent to 30 per cent is required to reduce the neonatal mortality and morbidity due to hypoxia. The oxygen concentrations must be periodically checked with a reliable oximeter. Feedings are withheld to obviate the possibility of aspiration. Digitalization is instituted as indicated by a failing heart. Neonatal metabolic and respiratory acidosis and hyperkalemia are treated by solutions of glucose, bicarbonate and insulin as recommended by Usher.[7] Antibiotic therapy may be instituted if infection supervenes.

As yet, no definite criteria exist for the clinical diagnosis of the respiratory distress syndrome. There is, however, agreement that a fairly strong presumptive diagnosis at least can be made during life, and that such a diagnosis can be corroborated at autopsy should the infant die. Certain additional values must, however, be accurately measured and evaluated before any great improvement in therapy can be achieved. The chemical status of infants who have, or are likely to develop the respiratory distress syndrome must be further investigated. Respiratory and circulatory functions cannot be separated. There is evidence which suggests that the ductus arteriosus normally remains open for several hours after birth.[8] It has also been demonstrated that the response of the neonate to hypoxia is a fall in peripheral arterial pressure below the pulmonary pressure, so that blood from the right heart would short-circuit the lungs via this patent ductus arteriosus.[9] This would re-establish, in effect, a "fetal circulation," which would contribute to the recur-

continued on page 96

THE B.M.R. OF YOUR ASSOCIATION*

IRVING A. BECK, M.D.

The Author. *Irving A. Beck, M.D., President, 1960, the Providence Medical Association.*

A MEDICAL ORGANIZATION, like any other group, be it scientific, social, or business, must periodically take stock and through its officers report thereon to its membership. As we have just heard, this may take the form of a financial report—so much received, so much spent; a secretarial report as to how many new members were added, how many lost; the number of meetings, and their respective attendance. These, and others, are the necessary details incident upon the functioning of a medical association. Are they, however, the true measures of our activities? In this annual report, I propose briefly to review some of our principal functions that justify our existence as an entity.

We elect the largest delegation to the House of Delegates of the Rhode Island Medical Society, and there our representatives determine and implement policies, participate in the invaluable committee work, and co-operate with other organizations in the general field of health and welfare. In a compact, largely urbanized state such as ours, many of the duties carried on in other areas by the county medical society are here more efficiently handled at the state level. Therefore, this association does not *per se* have many active committees, but our membership is very well represented on those of the state Society.

An important function is the monthly scientific program, which we should judge perhaps rather by the calibre of the speakers than by the attendance, which unfortunately has frequently not been commensurate. Perhaps some later president will tackle the problem of increasing the number of the "faithful regulars."

Two years ago in his Annual Address, Doctor Joseph McWilliams reviewed the work of our Medical Bureau, which provides a service not only to physicians and their patients, but to the community as well.

The screening of applicants for membership acts as a check upon their having satisfactorily completed the requirements for medical practice in this state, and helps maintain the quality of hospital staffs, as membership is usually a prerequisite to staff appointments.

One other activity offers a parameter by which our association may be rated.

"As the calorimeter tells the activity of the patient's metabolism, so you may determine the plus or minus activity of the local profession in any district by the condition of its library." So stated Harvey Cushing in 1926.[1] If we accept this as a possible standard, what would be the rate of the Providence Medical Association? The assemblage of books and periodicals housed in this building is properly termed the library of the Rhode Island Medical Society rather than of the Providence Medical Association. But there is an unique historical and current intertwining of the funds and volumes of the Providence Medical Association with its parent library, so that it must be regarded as a joint effort.

I shall not review in detail the history of the Library, fascinating and inspirational though it is. This was done and published by Doctor George Hersey in 1900,[2] to whom the Library owes its greatest debt; by Doctor G. A. Blumer in 1911;[3] its treasures were itemized by Doctor H. G. Partridge in 1924;[4] and Doctor John E. Donley, whose memory is still fresh, brought the record up to date in 1937.[6] I am sure that the forthcoming sesquicentennial history of the Rhode Island Medical Society will detail its beginnings, its travels, and its travails until its secure lodgement on these premises.

To quote from Doctor Hersey's scholarly address:

"The library of (the Rhode Island Medical) Society is the fruit of an early planting, for at the first election of officers in 1812, the Society chose a librarian. It is not probable that he had a hard time caring for books as he made no annual report, and asked for no appropriation, and as the office involved no duties, it was finally discontinued.

"The Providence Medical Association was organized in 1848, and about 1850 began taking the leading English and American medical journals. These long files of important periodicals, covering half a century, (now, of course, 110 years) have all

*Presidential Address delivered at the 114th Annual Meeting of the Providence Medical Association, at the Rhode Island Medical Society Library, January 2, 1961.

been incorporated in our library.... The PROVIDENCE MEDICAL JOURNAL (published by this association) was conceived in the hope of benefiting the Medical Library, as all journals received and exchanged and all books in review were placed on our shelves and preserved for future reference." This also happens to be one of the principal side-benefits of our own RHODE ISLAND MEDICAL JOURNAL at this time.

In 1880, the Providence Medical Association presented its "books, pamphlets, and medical journals" to the Rhode Island Medical Society and here began the union which has persisted until the present.

In 1911, on the occasion of the laying of the cornerstone of this building, Doctor Frank L. Day[5] stated, "The most marked feature of the library is the extraordinary number of bound volumes of the world's medical journals, often comprising complete sets. Many files of these journals have been contributed by the Providence Medical Association, which since its organization in 1848, has subscribed for the prominent, current medical journals, both American and foreign, and has deposited them in the library." This "most marked feature" has continued to be the responsibility of the Providence Medical Association to this day. Our association makes a substantial annual contribution to the Library for the purchase and binding of periodicals, and appropriates a sum for the use of the premises of the Rhode Island Medical Society as its meeting place—a practice dating back exactly one century, when the two groups shared the rooms of the Franklin Society on North Main Street.

A Committee on the Reading Room of the Providence Medical Association was appointed in 1877, and constituted annually until 1956, when its functions were consolidated with those of the State Society Library Committee.

One medico-literary mystery exists in the history of our library. In 1868, the "pathologic specimens, Books, and Pamphlets belonging to the Providence Medical Association" were presented to the Rhode Island Hospital, as were also those of the Rhode Island Medical Society. In 1880, the secretary of the association requested the trustees of the Rhode Island Hospital to return the journals, but no record exists, either of our own or that of the Rhode Island Hospital, as to whether they were. It is known that about 1930, there was a literary housecleaning at the Rhode Island Hospital, and except for some rare items salvaged by members of the medical staff, many old books and journals, presumably part of the above loan, were disposed of. Parenthetically, should any of those discriminating physicians who literally plucked these brands from the burning be present, may I express a plea for their eventual return—80 years after the original request—to this library. I can assure them that adequate recognition of their interim custodianship will be made. The mystery is that somehow the invaluable files of the periodicals—some subscribed to since the inception of the Society, such as the British LANCET, which dates from 1823—are intact. Did Doctor Hersey somehow get the periodicals back, or did he in some manner manage to fill in the missing issues? Considering the magnitude of the latter task, I suspect that he probably personally retrieved them, and this is why no formal record exists.

In evaluating the role of our library today, and through it our corporate metabolism, we cannot substitute the achievements of our predecessors.

"It is to be regretted that so few of the profession frequent the reading room. How to make the room more useful to physicians of Providence is a problem we would gladly solve.... Suggestions will be thankfully received." So wrote Doctor Hersey in 1880. Doctor Donley[6] quoted the observation that a library is a mausoleum, where knowledge lies dead and mummified unless its contents are circulated.

Can these criticisms be made of our library today? Let me inform you of the current functions of our Medical Library. It is still a delightful place to browse through journal, text, and per chance even fiction by some literary medico in the Davenport collection, but an adjustment to the tempo of the jet age has been made. Physicians, for many reasons, find it increasingly difficult to come to the library in person. Yet the need for consultation with the medical literature is on the increase. This and the frequent inability to find a nearby and legal place to park one's car, have resulted in the novel practice of the books going to the physician rather than vice versa. Through the initiative of our librarian, references on a subject of interest to a member are assembled, and the volumes may be withdrawn for leisurely study and abstraction in the home or office. Our library staff is generous with its renewals, and most gentle with its reminders to each of us delinquents—even though fines have been authorized for the past century. Of course, there is a limit to the extramural exile. By direct arrangement, volumes may be picked up and returned at other than the regular hours, and they may be even forwarded by mail. This then is a direct service to our members, and in 1959, some 221 bibliographies were prepared.

To the medical and scientific community generally, the library renders still another service. There are many libraries with material in the medical sciences in this area. There are those of the various hospitals and those of the state departments. The universities and colleges have large collections, particularly in the fundamental sciences,

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as does the Providence Public Library. Obviously, some material is duplicated, but often one of these libraries possesses periodicals or texts not present in another. To meet this situation, there was initiated in 1953 a Union List of Medical Journals. This project originated with the several librarians themselves, and at the present time comprises the periodical inventory of twenty libraries in this community. A patron of any of these libraries may, through the interlibrary loan service, have access to the local pooled wealth of medical literature. Needless to say, our library through its librarian was one of the leaders in this community project, and because of its much greater collection is the major contributor. During 1959, 548 journals and 59 books were loaned to other libraries in New England.

The lay press abounds with references to the selfishness of physicians. Does the public know that our library is constantly furnishing the public with directory-type material? Do they know that many college students, nurses, attorneys, members of other professions, and other interested individuals make constant use of our library facilities? That this category in 1959 numbered 1,015 individuals? If the general public were aware of these services and realized that all this is provided for out of your dues and the resources of our organizations, perhaps this type of attitude might improve.

What are the resources which provide these services? We have a building and stacks to house our volumes—bulging a bit it's true. We have a pleasant reading room—traditionally a responsibility of the Providence Medical Association. We have some 43,000 bound volumes, and one can only conjecture as to the amount still awaiting binding, and cataloguing. We subscribe to 430 periodicals. All these are the physical resources—but it takes more than paper and leather to perform the tasks I have listed.

"The testy librarian of tradition miserly of his treasures, impatient of interruption, is an extinct species." So wrote Harvey Cushing[1] in the paper from which I have taken my theme. I do not believe this type of librarian ever existed in this library. Our present librarian, Mrs. Helen DeJong, her predecessor, Miss Grace Dickerman, and the transient, but devoted assistants, have been the living machinery who have quietly and efficiently implemented the function above enumerated. To return to the dictum of Harvey Cushing,[1]—What then is the metabolic rate of this Association? If our support of the library and its tasks is any criterion, I feel we can justifiably conclude we are a hypermetabolic group.

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Grateful acknowledgment is made to Mrs. Helen DeJong for her assistance in assembling much of the above data.

TREATMENT OF RESPIRATORY DISTRESS OF THE NEWBORN WITH HUMAN FIBRINOLYSIN

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ring cyanotic episodes witnessed in the respiratory distress syndrome. Infants who develop this syndrome appear to have low systemic blood pressures at birth, and more reliable techniques to measure this parameter must be developed. Close observation of neonates who eventually develop respiratory distress suggests that these infants work harder to ventilate their lungs than do the normal newborn, even prior to the full blown clinical picture. Intraesophageal pressure readings would provide us with an index of this energy expenditure early in the development of the disease process. It is our contention that neonatal blood pressure and intraesophageal pressure readings are the two most important values in early diagnosis and the early institution of therapy.

SUMMARY

1. The syndrome of hyaline membrane disease is described and its etiological factors discussed.

2. The production of a similar syndrome in the guinea pig is described and the attempted dissolution of the membrane with a specific enzyme fibrinolysin in this experimental animal and the infant with respiratory distress is reported.

3. Further investigation must be directed toward the circulatory system; and the value of blood pressure and intraesophageal determinations in the neonate as a guide to diagnosis and treatment is stressed.

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THE PROBLEM OF UNEXPLAINED UPPER GASTROINTESTINAL BLEEDING*

ROMAN R. PE'ER, M.D.

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GASTROINTESTINAL HEMORRHAGE is a catchall term, embracing a number of different diseases. Various causes and sources of bleeding demand different approaches and treatment. For instance, a hemorrhage from varicose veins of the esophagus has an entirely different background than bleeding peptic ulcer or erosive gastritis and will require a different treatment.

The causes of bleeding are many. I should like to go over them quickly, just to show their variety. The intragastric causes are: peptic ulcer, benign or malignant tumors, hemorrhagic gastritis, venous talengiectasia of the mucosa, hiatus hernia, ruptured sclerotic vessel or aneurysm, and trauma. The extragastric causes may be in the esophagus, such as varicose veins, diverticula, erosions or esophagitis and foreign bodies; or in the duodenum or small intestine, such as ulcers, tumors, erosions and diverticula. There are also causes completely unconnected with the gastrointestinal tract, such as thrombocytopenic purpura, hemophilia, and vitamin K deficiency.

The degree of bleeding may be roughly classified as *massive*, and *recurrent, nonprofuse* hemorrhage. Esophageal and gastric varices account for 10% of cases of massive hemorrhage, while peptic ulcers claim a lion's share, about 80%. All other causes, such as gastritis, esophagitis, hiatus hernia, and blood diseases between them account for the remaining 10% of the bleeding patients.

I should like to exclude from this discussion all patients with liver cirrhosis and chronic peptic ulcer because their condition and history, in most cases, is known in advance; and they can be treated on that basis. Let us concentrate on the remaining causes of hemorrhage, which are mostly unknown at the time when the patient is admitted to the hospital.

*Presented at a Regular Meeting of the Providence Medical Association at the Rhode Island Medical Society Library, Providence, Rhode Island, October 3, 1960.

Because of the serious condition of the bleeding patient, the usual routine examinations are not always permissible, and very often the surgeon is called for an emergency operation. Delay in making a decision, with constant or recurrent blood loss, lowers the patient's ability to withstand an inevitable major operation, while a prompt decision puts a surgeon in the position of having to work in the dark. If the patient with a known source of hemorrhage presents a multitude of difficulties, a patient with an obscure source of bleeding presents even more problems. These are the cases which tax our professional ability to the utmost, yet the results can be very disappointing, when we are unable to detect the source of bleeding, or to explain the cause.

Normally, when laparotomy and routine palpation of the abdominal contents fail to show the source of the bleeding, gastrotomy, with or without duodenotomy, is done. Constant irrigation of the mucosa is of great help in visualizing small erosions or a ruptured vessel. Careful attention is paid to the posterior wall of the stomach or duodenum because a gastric ulcer usually erodes into the left gastric artery and duodenal ulcer into pancreaticoduodenal artery. In that way, the hemorrhage which was obscure at the time of the patient's admission can be detected and dealt with.

But, strange as it may seem, it happens sometimes that a surgeon is unable to demonstrate any evident source of bleeding, even with a most careful and skillful examination. This situation has been reported many times from various hospitals and the term "obscure" or "unexplained" bleeding has been applied. Some surgeons have reported as many as 10% of all operated patients with massive hemorrhage in this group. Our percentage is somewhat smaller. I feel that the exact number doesn't matter, but rather recognition of the fact that such a situation does exist at all.

Taking into consideration that 70-80% of possible causes of bleeding are located in the stomach, purely from an anatomical point of view, subtotal gastric resection has been recommended. It has become more or less the accepted procedure since the publication by the Mayo Clinic in 1954 of satisfactory results with this operation.

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Nevertheless, the decision for resection is taken solely on empirical experience and not on a solid scientific basis.

What bothers me most in these cases is the uncertainty which follows such surgery. Very often we are forced to operate upon patients who present great operative risk, due to a number of extraneous factors. We face these risks cautiously because we know that operation is the only means of cure, and together with adequate pre- and post-operative treatment we have in this approach the best hope of saving the patient's life. However, confronted by the patient with obscure bleeding, we don't know for a very long time if our operation was a success or a failure; and with the best of post-operative treatment we can encounter recurrent hemorrhage. Thus we are faced with exactly the same calamity for which the patient was operated upon. Imagine how distressing it is for a surgeon to perform a major operation upon a severely ill patient without being able to tell if the operation was really adequate or not.

Besides the moral problem, we have before us a technical problem too, due to the fact that we are working in the dark. Our approach is based on the fact that the method has worked well in such and such number of cases and should, therefore, work well also in the case at hand. Yet the present case can be entirely different from the previous ones. We proceed on the strength of the French saying *on fait se qu'on peut . . .*, which means *we do what we can*, but this obviously not always is what should be done. However, till now we have nothing better, and in my humble opinion high gastric resection should continue as the best solution. Half measures will prove even more disappointing.

I still remember, some few years ago, Doctor John Garlock of Mount Sinai Hospital, then Visiting Surgeon in Israel, performing a laparotomy because of gastrointestinal bleeding of obscure origin. After careful examination of the stomach and duodenum, from the outside and inside, no source of bleeding was evident. He ligated all major vessels around the stomach. The patient did well for a couple of days, then succumbed to a second hemorrhage.

About a year later, I, myself, was faced with the problem of a fifty-year-old, obese woman, a new immigrant, brought straight from the ship to our hospital, with massive gastrointestinal bleeding. I too failed to demonstrate the source of bleeding, but remembering the previous case, did a subtotal gastrectomy and the patient recovered nicely. The ironic fact was that the pathologist failed to determine the cause of bleeding on the examination of the specimen, but the patient did well during a two-year follow-up.

Four months ago I was consulted in the case of a twelve-year-old girl with severe diarrhea and melena of a week's duration, for which she already had received ten blood transfusions (of half a liter each) and all possible medical treatment. At operation I found no blood in the duodenum or jejunum, but the lower part of the small intestine, as well as the colon, was full of blood. In the ileum I found a 20 cm.-long Meckel's diverticulum, which I excised. Three days later, in the middle of the night, the girl again had fresh bleeding which proved fatal. On post-mortem examination erosions of all the mucosa of the gastrointestinal tract were found. Could I save her by doing a gastrectomy in addition to resection of the diverticulum? I don't know.

While it is conceded that massive hemorrhage is a difficult problem to handle, its serious nature makes it easier for an internist to decide in favor of operation, and for a surgeon to perform it because there is no other choice. But recurrent, non-profuse bleeding, having nothing of the element of urgency, can lead to disastrous results if a prompt decision is not made. And here, it often happens that all available means of examination fail and, for all practical purposes, we are confronted in this group too with unexplained bleeding.

In a recent statistical study of 300 patients with gastrointestinal bleeding, reported by the City Hospital of Cleveland, in thirty-three cases (or 10%), the source of hemorrhage remained obscure despite repeated examinations of the gastrointestinal tract. Our experience in Israel is about the same and we feel that if all other means fail, exploratory laparotomy must be performed as the last means of examination at our disposal.

Sometimes I feel that there is hesitation about laparotomy as a method of diagnosis. There are doctors who repeat the same examinations again and again, being afraid that referring the patient to a surgeon for exploratory laparotomy is a sign of diagnostic defeat, which obviously is not true. The time lost usually works against the patient. My belief is that after a second episode of bleeding, if a thorough roentgenological examination is of no help, the patient should be explored and the treatment decided upon on the basis of this exploration. I will better support my statement by reporting just one case history which may perhaps be of interest.

Case Report

This is the story of a thirty-four-year-old woman, the mother of three children and a teacher by profession. I mention her profession to emphasize the fact that we are dealing with an intelligent, educated person, one not expected to be a victim of her own negligence. She was healthy and working steadily until 1951, in which year she had a sudden attack of abdominal pain accompanied by tarry stools. A

year later, in 1952, she had a second attack of pain and melena. She was sent to a hospital, examined, and nothing was found. After a few days, the melena subsided, and she was discharged.

During the next three and one-half years, she had four attacks of abdominal pain, localized in the right upper abdomen with radiation to the right kidney. These attacks were followed by diarrhea and melena of short duration. She was hospitalized six times and examined by a score of doctors. During this period, five complete gastrointestinal series were done and in no instance was any abnormality found. Gynecological and urological examinations, as well as gastroscopy and sigmoidoscopy, failed to demonstrate anything pathological. All laboratory examinations proved negative, with the exception of the blood sedimentation rate, which fluctuated somewhat.

A diagnosis of possible peptic ulcer was made, but it contrasted so sharply with the clinical picture, that no surgical treatment was suggested. She was a fat, florid-looking woman, good humored and uncomplaining. She was discharged from her last hospital admission with the following conclusion: Her diarrhea and abdominal pains were of neurogenic origin. Melena was unexplained on the strength of all negative findings.

In 1956 she fainted on her way to school and was brought to our hospital in a state of shock. She had persistent diarrhea with tarry stools, and her hemoglobin had dropped to 6 grams. But she responded well to transfusions and after a week all examinations were performed again, and again failed to demonstrate anything abnormal, except a slight anaemia and an elevated blood sedimentation rate. I must say that she was examined very completely, from her mouth down, but nothing was found. She was still very obese (on her admission she weighed 171 pounds). On palpating her abdomen, only soft fat could be felt, and nothing else.

Laparotomy was recommended, to which she agreed. On operation, a small retroperitoneal cystic mass was found, originating from the second (retroperitoneal) part of the duodenum and lying below the transverse colon, medial to the ascending colon. The tumor was dissected out and part of the duodenum from which the tumor originated was resected.

On examination of the specimen, it proved to be a leiomyoma of the duodenum, full of fresh blood and old clots. The tumor had eroded into the duodenal mucosa and in the middle of the erosion one open blood vessel could be seen which was obviously the source of bleeding. Fortunately, no signs of malignant sarcomatous degeneration of the leiomyoma was found. She recovered very well after the operation and continues to be well on her four-year follow-up.

I must say that, in this particular case, it was really impossible to make a proper diagnosis by means of any routine examinations. The erosion into the duodenal mucosa was so small that it easily escaped detection by means of barium filling and, because of its retroperitoneal location and the obesity of the patient, the tumor could not be detected by physical examination. Exploratory laparotomy was the only way of elucidating this case of obscure bleeding.

Conclusions

1. The common causes and management of hemorrhage from the upper gastrointestinal tract are well known and hence have not been discussed. Stress has been laid rather upon the subject of obscure bleeding from this area.

2. Subtotal gastrectomy in all cases of unexplained massive bleeding appears to be the best treatment available, notwithstanding the fact that it is based upon purely empirical grounds.

3. Exploratory laparotomy is recommended as the only diagnostic method of value in unexplained recurrent, non-profuse bleeding from the upper gastrointestinal tract.

TUMORS OF THE TRACHEA*

RUDOLPH W. PEARSON, M.D.

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DYSPNEA, wheezing, cough, hemoptysis, and cyanosis are the classical signs of respiratory disease. Wheezing is a sign of obstruction; cough is an indication of irritation; hemoptysis signifies ulceration; and cyanosis a badly diminished transfer of air. These are frequently seen as a result of mediastinal, pulmonary, or bronchial disease, but are unusual as signs of primary disease in the trachea. This is emphasized by the low incidence of only thirteen cases in thirteen years at the Rhode Island Hospital, an institution of about 600 beds. Approximately 175 bronchoscopies are performed in this hospital each year. This then gives an approximate ratio of 1 to 175. These thirteen cases include one tumor of origin elsewhere than in the trachea, ten cases of proven primary tumor, and two of doubtful origin. Cases of encroachment from immediate structures, such as the esophagus, are not included. The literature contains reports of a variety of tumors, including: papilloma, adenoma, mixed tumor, cylindroma, carcinoma, lipoma, fibroma, chondroma, osteoma, lymphoma, rhabdomyoma, sarcoma, angioma, endothelioma, and amyloid tumor. Fifty per cent of these are benign, 29 per cent of cartilaginous origin.

In reviewing our experience at the Rhode Island Hospital, I should like to begin with the infant group. Diagnosis is difficult in the infant purely on the basis of its small size. The type of stridor which has been attributed to soft cartilages, to absence of tracheal rings, to a non-rigid epiglottis, and to bizarre neurogenic reflexes is sometimes noted in the presence of an hemangioma. This tumor is seen in the proximal portion of the trachea, fluctuating in size with distention of its component blood vessels. When it becomes enlarged with crying or straining it may produce dyspnea, cough, cyanosis, and sometimes death. Other tumors are very rare in the infant, but in older children papillomata may arise as primary tumors in the trachea. They are, of course, not limited to the trachea, but tend to spread to the larynx and bronchi, and present a very difficult problem in therapy. We have seen only one hemangioma and one papilloma in this age group. These will be reported elsewhere.

Among the thirteen cases in the adult classification we have had four adenomata, six carcinomata, two of the undifferentiated variety and four of epidermoid or squamous cell type, one benign polyp, one lymphoma, and one melanoma. The average age in this group is sixty-two. The youngest was forty-four and the oldest seventy-five. The melanoma is included, despite the fact that it was metastatic, because it produced gross obstruction and presented a problem in care. Treatment was obviously palliative, and consisted of three procedures: The first was endoscopy and resection with biting forceps, the second tracheostomy with removal of tumor through the tracheostomy stoma, and the third laryngofissure, since the tumor obstructed the entire subglottic and upper tracheal airway. This was ten years ago, before chemotherapy had any impact on the treatment of malignant disease.

In all cases the chief complaint was shortness of breath or dyspnea. The second complaint was cough, the third wheezing, and the fourth hemoptysis. The wheezing was noted to be primarily inspiratory and expiratory, as compared with the usual expiratory wheeze found in bronchial asthma.

The carcinomata were handled in various ways according to the problem which presented. In one case the primary tumor was removed by resection of a segment of trachea approximately 2 cm. in length. The defect was closed, and no obstruction occurred until death several months later. In another case, that of an elderly woman who refused to submit to surgical excision of a primary tumor, an attempt was made to palliate her symptoms by radiation, but the outcome was fatal. In still another instance an epidermoid carcinoma, in a man of advanced years harboring a simultaneous adenocarcinoma of the large bowel, was treated by insertion of radon seeds in an attempt to control hemoptysis, which was becoming a major problem. Both the hemoptysis and obstruction were controlled.

An undifferentiated carcinoma, located in the

*Read before the New England Otolaryngological Society at the Massachusetts General Hospital, Boston, on November 16, 1960.

lower trachea at the junction of the left main bronchus, was treated by X-ray therapy. This recurred a year later with some extension into the lung substance. It was again treated with X ray, and palliation accomplished for many more months. The tumor, according to the findings at necropsy about two and a half years following the original discovery of the tracheal pathology, was then proved to be related to a breast tumor which had been removed fifteen years prior to the onset of the tracheal disease.

A simple polyp in the trachea is perhaps the easiest tumor to remove, and this can be accomplished either piecemeal through the bronchoscope or by resection of its sessile attachment to the tracheal wall.

The most interesting of tracheal tumors are the adenomata, sometimes referred to as cylindromata. Of the four that we have to report three appear to be benign and the fourth malignant. The malignant tumor was reported at autopsy with multiple metastases all related to the adenomata of the trachea which had undergone malignant changes.

The three benign tumors have responded to the most conservative type of management. The first case, that of a woman in her early fifties, complaining of wheezing in her chest, was found to have a shadow in the right upper lobe on a routine chest X ray. This proved to be a partial atelectasis due to a moderate obstruction of the right upper lobe which was the result of encroachment on the right main bronchus by an adenoma at the lower end of the trachea. After surgical consultation the decision was in favor of bronchial fulguration because of the location of the tumor, and because the probable restoration of patency of the right main bronchus and trachea would be inadequate for further function. This was carried out in seventeen subsequent bronchoscopies, and an excellent result was obtained. During the past three years there has been no evidence of tumor and all of the streaking in the right upper lobe seen in chest films, due to obstruction of the air column, has disappeared.

A woman of seventy-five years of age, long treated for asthma, was found by another physician to have an inspiratory as well as an expiratory wheeze, and wheezing above the carina rather than below. Despite essentially negative X rays, she was bronchoscoped. A multinodular tumor was disclosed in the midportion of the trachea, occluding about 75 per cent of the lumen. Biopsy was obtained, and the diagnosis proved to be epithelioma adenoides cysticum of the trachea. Fulguration of the tumor brought about its complete destruction without invasion of the peritracheal tissues. A complete cure seems likely since, over a period of three years, she has had no evidence of recurrence. Recent tomograms show no evidence of tumor in her trachea nor in the surrounding tissue.

Another interesting case is that of a short, obese, and very cyanotic woman who was admitted to the hospital through the accident room one night for an emergency bronchoscopy. A large rubbery type of tumor was visualized at the level of the carina, obstructing almost totally the right main bronchus, and most of the left. By rapid and frequent biopsies the massive tumor was diminished in size to allow ventilation of the lungs. This was aided by administration of oxygen. An early diagnosis of lymphoma was obtained, and a very dramatic response was accomplished with X-ray therapy.

Tracheal tumors, benign or malignant, present varied problems in diagnosis and treatment. It should be emphasized that in those suspected of having asthma because of inspiratory wheezing, the virtual absence of wheezes within the chest on stethoscopic examination, should point to a tracheal tumor. The diagnosis then becomes an endoscopic problem because X-ray studies seldom show such tumors, unless they have advanced to a stage where they encroach on the airway or into the lobes of the lungs. Biopsy proves the histology, and helps to indicate the type of treatment. The treatment may of course be surgical excision, together with, in some cases, restoration of the structures with proper prosthetics. The use of X-ray therapy in certain types of tumors is certainly indicated, but the more usual approach is through the bronchoscope, when surgery is contraindicated by virtue of age, disability, or accessibility of the tumor. The bronchoscopist can utilize fulguration, insertion of radon seeds, or by his special instruments, resection or biopsy to destroy or remove the tumor, and bring about a resolution of an otherwise extremely difficult problem.

150th Annual Meeting
May 2 and 3, 1961

PEDIATRIC METAMORPHOSIS

GERALD SOLOMONS, M.D.

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IN THIS ERA of psychiatric orientation, many therapists advocate the practice of "writing down on paper" exactly how one feels about a particular event or situation. I have endeavored to do just that on the first anniversary of my decline or ascension (depending on how you feel about these things) to the status of "full-time researcher." I indulge in this mental catharsis to prove to myself and friends that the constant state of euphoria presently enjoyed is genuine, and that I really like my job.

In 1959 after several years in the private practice of pediatrics, I took a full-time job as pediatric co-ordinator of the Child Development Study in Providence, Rhode Island. The Child Development Study is a joint endeavor between the Institute for Health Sciences at Brown University, Providence Lying-In Hospital, and several other hospitals and agencies throughout the state. This is one of fifteen similar projects being conducted across the country under the sponsorship of the National Institute of Neurological Diseases and Blindness, the national project being known as the Collaborative Study of Perinatal Factors in Cerebral Palsy and Neurological Disorders.

My reasons for leaving practice were purely personal and were not due to ill health or lack of success.

Having been trained and conditioned for so many years to cope with the pressures and frustrations of private practice, such as the telephone, parents, appointment schedules; the transition to full-time research was a startling one. Initially I wallowed in the luxury of time, but after a few short weeks I became restless with the unaccustomed tranquillity. The feeling was akin to that experienced shortly after giving up smoking—there was no place to put my hands.

I was still examining four-month and one-year-old infants on a daily basis, but my patient load was now no more than six, a number easy to handle after my former work day. The examination of each was done quickly, and I thought competently, with no great effort on my part, as the findings were recorded on a printed form with various check-marks for the normal, and a brief description of the abnormal. I could take as much time as needed for the examination with frequent interruptions for comforting of the infant if necessary. The diagnosis at the conclusion was purely my impression of the present status of the child. The one discordant note was that I knew nothing whatsoever about the history of this patient, had never seen him before, and could not acquaint the mother with my findings, interpretation, prognosis, and treatment. In short, I could not render a service. This was hard to take after being an oracle to so many people for such a long time, and my being naturally talkative and outgoing added to the burden. At times I must admit there was an inward feeling of smug complacency as I found some minor aberration from the normal I assumed the child's private physician had missed. Mainly however, there was the belief that if a few more practical clinicians such as I were on this project, the answers would be found in half the time, with half the effort. Too many impractical scientists and thinkers were in research. My whole attitude could be summed up in the phrase "too much singing and no opera."

At this time, whether by accident or design, I was appointed to a national committee, meeting regularly to plan one facet of this huge undertaking. It was composed basically of three pediatricians and three psychologists, and I approached this assignment with the same magnanimous, bemused tolerance I had acquired. At the meetings I solved the problems discussed with speedy practical solutions which showed to full advantage my years of clinical experience. Instead of the admiration expected, my arguments were coldly and methodically dissected by my colleagues on the committee, and were proved to be unscientific, incapable of quantification, uncodable, and therefore of no statistical value. The practicality was cheerfully admitted, but the results obtained would be utterly useless for scientific research.

So began my metamorphosis and change in outlook. I began to look at the infant system by system, organ by organ, in contrast to the "total child" concept of my previous pediatrics. In the past, palpa-

tion of the abdomen was performed to exclude the abnormal. My mind and fingers were trained to ignore everything other than the signs of disease. Now I had not only to feel the liver edge, I had to delineate it at so many centimeters below the costal margin. The infant previously recorded as hypertonic, now had to be rated quantitatively according to a five-point scale, and the suspicious case had to be spelled out in detail before such a label could be applied.

Going back over my records I found that my early examinations were not as good as I thought they were. More detail and accuracy could have been present and much of what I had written did not quite make sense, and would be incomprehensible to a statistician compiling a punch card from this collection of data. The illegibility of my writing was an embarrassing overtone necessitating no small effort on my part to decipher. There was, however, the comforting finding that my clinical impressions were fairly good and the analysis of each case was sound. I had the experience of private practice to help me disregard the bizarre abnormal sign or emphasize the almost indefinable clue that points the finger of suspicion.

The Child Development Study is composed of many disciplines, the psychologist, social worker, geneticist, nurse, lay interviewer, and my attitude to all these has changed, I'm glad to say. Formerly I tolerated such people as a necessary evil, assigning them a lesser role in the field of science, and attributing to them a different language of communication. (To be fair, this is the attitude held by many M.D.'s.) Working closely with them now I am of the belief that the psychologist may well be able to tell, more than I, the prospective growth and development of the infant in the first few months of life. This I did not believe before, and if I did, I would not have admitted it. It was also a shock to discover that the lay interviewer, with no previous training, could obtain a better comprehensive history from a mother about all the things that had happened to her child and family since her last visit. To be sure, my history was superior in those areas dealing with possible disease, but was woefully inadequate in assessing the stress and strain of family living which influence the child's growth and development.

I have more time for reading now, and have become more selective and critical of those articles I do read. Formerly my interest was directed mainly towards therapy and diagnosis, but now the scientific approach to the problem has assumed a greater importance. "Hypothesis" and "methodology" have become words of daily usage, and what is more I understand what they mean. I honestly do not think that previously I had the interest or the ability to evaluate the merits of a scientific article; the results were all important and the monograph was approved or condemned on this basis alone.

According to Davidson, "The art of arriving at a correct diagnosis is, or should be, based on at least three processes. The meticulous collection of evidence from every available source, recalling all of the conditions which may account for the symptoms, and evaluating the material."[1]

In conclusion then, I think my research training is helping me towards attaining the goal of the "Compleat Pediatrician."

REFERENCE

[1]Davidson, W. C.: The Compleat Pediatrician, Duke University Press, Durham, North Carolina, 1949, page vi

A PHYSICIAN VIEWS CONGRESS

ACCORDING to a recent item in the Journal of the American Medical Association, six of nine physicians who ran for Congress were elected. In addition, one Senator and a delegate to Congress from Puerto Rico are physicians. From the earliest times, doctors in America actively participated in political affairs. Among these was Benjamin Rush who was elected a delegate to the Continental Congress on July 20, 1776 and signed the Declaration of Independence on August 2, 1776. The following excerpts from his letters are of interest:

(To His Wife Jewel, Tuesday night, 23 July 1776)

"I am happy in finding that my appointment in Congress gives you so much pleasure. I believe it has operated in the manner you expected upon some of my old friends. I spoke for the first time this day about ten minutes upon a question that proved successful. I felt that I was not thundering like Cato in the Utica of our committee of inspection. The audience is truly respectable. Dr. Franklin alone is enough to confound with his presence a thousand such men as myself. I hope, however, in a little time to experience the same freedom and confidence in speaking that I observe in other members. I find even our illustrious body is marked with features of human nature. We can talk nonsense now and then as well as our neighbors. This reconciles me to myself. . . .

. . . Think, my love, how long our house must be left without a head in my necessary attendance upon Congress. . . . My attendance in Congress does not hurt my business, having as much to do as ever. My wages in Congress are 20/ per day. Good night, my charming girl."

* * *

(To a Friend, one Dr. Walter Jones, July 30, 1776*)

"What shall I say of the august Assembly of our States? It is a wide field of speculation. Here we behold the strength and weakness of the human understanding and the extent of human virtue and folly. Time will meliorate us. A few more misfortunes will teach us wisdom and humility, and inspire us with true benevolence. The republican soil is broke up, but we have still many monarchical and aristocratical weeds to pluck up from it. The history of the Congress that will sit in the year 1780 will be the history of the dignity of human nature. We have knocked up the substance of royalty, but now and then we worship the shadow. O! liberty, liberty, I have worshipped thee as a substance and have found thee so. The influence of the declaration of independence upon the senate and the field is inconceivable. The militia of our state pant for nothing more than to avenge the blood of our brave countrymen upon our enemies on Staten Island.

"Adieu, my dear sir. Continue to enlighten your fellow citizens in the doctrines of a free government. Make them wise and virtuous, and they will be happy. — Yours sincerely, B. Rush"

*From the *Letters of Benjamin Rush.* Edited by L. H. Butterfield. Published for The American Philosophical Society by Princeton University Press in 1951.

ACKNOWLEDGMENT OMITTED

Inadvertently our printer omitted the important acknowledgment of the original publication of the article — *Leonardo and Vesalius, The Two Roads: Surgery and Science* — which appeared in the January, 1961 issue of the RHODE ISLAND MEDICAL JOURNAL.

This article first appeared in the HARVARD ALUMNI MEDICAL BULLETIN, Vol. 34, No. 3, April 1960, and our reprinting with the permission of this Bulletin should have carried the notation of the original source.

THE EDITOR

Editorials

ARE THESE DRUGS SOLD UNDER GENERIC NAMES?

In the Providence Journal of November 21, 1960 under the by-line of Mr. Selig Greenberg an article appeared titled *The Cost of Medicine,* in which the medical profession is taken to task for lack of zeal in effecting savings by prescribing drugs under their nonproprietary, rather than their registered brand names. We have already commented editorially upon this subject, pointing out some of the problems involved. Furthermore the Society and several hospitals have taken measures in pursuit of the desirable goal of reducing the costs of medications by this approach.

In this article Mr. Greenberg states: "It is ironic, if nothing else, that while the code of medical ethics sternly forbids physicians to advertise, medical societies now generally find themselves in the advertising business up to their necks. This has led some observers to question whether organized medicine can be expected to maintain a truly objective attitude toward the business from which it derives its principal support." It is possible to state categorically that the policy of this Journal and of the Society of which it is the organ are completely independent of and resistant to any influence by the pharmaceutical advertisers who use its pages. We are further willing to state that the ethical drug advertisers in actuality conduct themselves in our experience in a manner wholly circumspect and beyond reproach in this matter. The implications in the quoted lines are quite gratuitous.

In contrast to our position, we should like once again, as we have before in these columns, to call attention to a different attitude displayed by the same lofty newspapers which seem to derive great satisfaction in taking contemptuous pot shots at the "bewildered physician" and "the purveyors of pills." We have in previous issues commented on the continuous sordid display of patent medicine advertisements (see cut) in the local daily press. Not only is the advertising in atrocious taste, but it is a major and distinct disservice and danger to the unprotected public. Pleas for self-medication, as we have pointed out before, lead to self-diagnosis and the postponement of proper and timely medical care. Where actual positive damage is not done, the public is urged to spend its hard-earned money on inactive or inert preparations. Despite the conscientious scrutiny of the Federal Trade Commission and the Food and Drug Administration there is no dependable assurance that some of these nostrums do not contain harmful substances.

Furthermore, with regard to price, we can point out for example that a brand of aspirin advertised in these newspapers sells for fifty-nine cents a hundred tablets, while, under its generic name in U.S.P. quality, the way it is generally prescribed by physicians, it can be obtained for one dollar and twenty-five cents per thousand. Is this not a case of the pot calling the kettle black?

We submit that if these newspapers which profess such a strong interest in the medical welfare of its readers are sincere, and furthermore are as independent of the influence of its advertisers as we are, they will forthwith stop this disreputable disregard of the interests of its readers. Only by ceasing immediately the printing of this offensive and dangerous hogwash and by taking a strong editorial stand against it, can they atone for the positive harm that has been perpetrated upon the public in the past by this abuse of the public trust.

continued on next page

DR. ARTHUR HILER RUGGLES

ONE OF THE MOST distinguished and beloved physicians of Rhode Island died on January 2. Known nationally and internationally as a leader in psychiatry and mental hygiene, and to patients and friends here in Rhode Island as a kind and able counselor, he was always ready to help those in need of his advice.

He was born in Hanover in 1881, received his A.B. from Dartmouth College in 1902 and his M.D. from Harvard Medical School in 1906. In 1910 he was given the degree of A.M. by Dartmouth, and in 1926, 1929, and 1949 he was awarded the honorary degree of Doctor of Science by Dartmouth, Brown, and the University of Rhode Island. Following his internship at Rhode Island Hospital he became assistant physician at Butler Hospital, and in 1912 he went to Munich and studied under Professor Kraepelin. Following World War I he returned to Butler Hospital where in 1922 he became superintendent, succeeding another of Rhode Island's most distinguished physicians, the late Doctor G. Alder Blumer.

During his twenty-six years at Butler Hospital, from which he retired in 1948, he carried on the therapeutic, educational, and research functions of that institution in a way which enhanced its local and national reputation, conferred the priceless blessing of skillful and kindly treatment on its patients, and aided many young physicians to perfect themselves in the science and art of psychiatry. His happiness when the hospital weathered the crisis of a few years ago that almost caused its destruction has been a joy to family and friends and his presence, when he has been able, despite ill health, to get to meetings at the hospital has been an inspiration to all who were present.

Doctor Ruggles' distinguished war service, first in a British war hospital and later as division psychiatrist to the Second Division of the American Army, and the award to him of the Croix de Guerre by France were followed by a peace-time career of even greater distinction. Among many other things he served ten years as president of the American Psychiatric Association and eight years as president of the National Committee for Mental Hygiene. He was elected president of the First International Congress on Mental Hygiene, which was held in Washington in 1929 and represented the United States at the second Congress in Paris. He also took part in the educational work of Yale University as consultant and lecturer.

Here at home his public service was outstanding. He was consultant to several governors of the state and was a member of many committees and councils. He was president of the Providence Medical Association and later of the Rhode Island Medical Society in 1947-48, a time when many difficulties arose and his wisdom and tact were needed.

These are but a few of the many things that Doctor Ruggles did for the community in which he lived. An account of them, however, does not by any means suggest the real meaning and value of his life as he lived it here in Rhode Island. To appreciate what he really meant to his fellow citizens one must have known him intimately and have felt his warmth, vitality and kindness.

EARLY LAVATION

IN A RECENT rather convincing paper in the ARCHIVES OF SURGERY (December, 1960) Doctor Carl J. Heifetz of St. Louis suggests the logic and practicability of early postoperative bathing. He enumerates the measures that have furthered the early restoration of the patient to a normal status, such as early ambulation, acceleration of dietary progression, and early return to normal occupation. Many of these ideas, which caused raising of eyebrows when they were initiated, have now been generally adopted. Early ambulation was practiced in European clinics a generation ago because of the lack of nursing personnel, but it received its main impetus in this country, along with other methods of early rehabilitation, during World War II, when the Armed Forces were obliged to seek out the most effective methods of getting large numbers of sick and wounded back to duty at the earliest possible moment.

More recently the feasibility of removing surgical dressings early or dispensing with them entirely has been recognized. Doctor Heifetz himself was one of the earliest advocates of this practice (1952), and it is being used increasingly in our area. Experimental evidence, he points out, indicates "that clean, well-coapted surgical wounds . . . are sealed by a coagulum of fibrin and red cells within a matter of minutes, and that this seal is an effective barrier against bacterial contamination from external source." The truth of this concept has now been repeatedly confirmed in clinical practice, and those who have followed this principle are enthusiastic about its advantages.

Carrying his reasoning one step further, Doctor Heifetz now argues that the postoperative care of

patients would be simplified if they could resume, early in the postoperative period, normal bathing habits. Consequently he permitted 100 patients with 107 wounds, on whom dressings had been omitted entirely or removed early, to bathe or shower at will beginning on the first or second postoperative day. The first couple of baths were usually taken with the help of a nurse, aide, or orderly. He concluded that early bathing had no adverse effect in healing, that it simplified nursing care, and cleansed the skin better than the routine bed bath.

We find this suggestion very appealing and worthy of trial, but feel that the designation early postoperative bathing is not quite pretentious enough. The term early ambulation, of course, means nothing more than early walking. We are reminded of the pungent comment of our editorial predecessor, the late Doctor Peter Pineo Chase, who when told by a patient that another doctor had suggested that Doctor Chase palpate his abdomen exclaimed with his characteristic elision of the letter "L," "Oh, H...! That's just feewing the bewwy." In order to give this revolutionary concept of early postoperative bathing proper dignity and status we suggest that it be called early lavation.

AUTOMATION IN THE HUMAN BODY

STRIKING THINGS are taking place these days in the replacement of human tissues and mechanisms by non-viable artifacts. Vascular replacements with plastic prostheses have become commonplace, and the replacement of cardiac valves with fabrics and mechanical ball-valve gadgets have already been carried out with some success.

Nothing is more spectacular, however, than a recent announcement of a self-contained, implantable pacemaker for the long-term correction of complete heart block. A myocardial pacemaker with wires brought out through the skin has already established its feasibility in the management of atrioventricular block complicating the surgical repair of septal defects. Previous to that a practical method using skin electrodes, but in the somewhat higher voltages, had already been in use in cases of patients with Stokes-Adams syndrome due to heart block uncontrolled by drugs and usually a sequella of coronary occlusion.

The techniques of miniaturization through the use of tiny transistors, capacitors, and long-acting batteries now make possible the fashioning of a semi-permanent pacemaker imbedded in biologically inert plastics, which can be surgically implanted in the body on a long-term basis. Chardack, Gage, and Greatbatch* of Buffalo, New York, have recently described such an apparatus 6 cm. by 1.5 cm. in size with a transistorized circuit containing only 8 components, and powered by mercury cell batteries, with a shelf life of ten years. The expected functioning usefulness of the apparatus is five years. The pacemaker itself is implanted in the abdominal wall and the wires leading to the cardiac electrodes are also buried within the parietes.

A total of eight patients have already been subjected to this procedure with apparent success, three over a period of several months and long enough apparently to have established the practicality of the method.

This spectacular contribution to our medical armamentarium is indeed an auspicious portent and indicative of the wave of the future.

*Chardack, W. M.; Gage, A. A., and Greatbatch, W.: A Transistorized, Self-contained, Implantable, Pacemaker for the Long-term Correction of Complete Heart Block, Surgery 48:643, (October) 1960.

SCHOOL HEALTH LEGISLATION

IN SEPTEMBER, 1959, the then Governor, Mr. Del Sesto, appointed a committee, with the advice of the state director of health and the state commissioner of education, known as the Advisory Council on School Health Programs. The function of the Council, in the words of the Governor, was "to explore and to make recommendations towards establishing an adequate, uniform, statewide school health program."

The superintendent of schools of Bristol was named chairman of the Council which included representatives of interested professions, including three from the Rhode Island Medical Society. A number of meetings were held over a period of thirteen months at which the Council was able to simplify and codify the existing general laws of Rhode Island as they related to child and school health.

The Council submitted proposed legislation (House Bill 1521) which was introduced in the House of Representatives of the General Assembly, but which was never brought out of the committee to which it was referred. The legislation should be re-submitted this year, and possibly strong medical support might be of help in bringing it to the floor of the House and Senate for discussion and enactment. The changes as made by the Council were and are politically acceptable, and in the opinion of the study group they have the rather wide sweeping effect of simplifying the existing old regulations.

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

At a meeting of the Newport County Medical Society held at the Newport Hospital on January 17, 1961, the following officers were elected to serve in 1961:

President.....José M. Ramos, M.D.
Vice President.....Donald B. Fletcher, M.D.
Second Vice President.....Charles A. Serbst, M.D.
Secretary.....Richard R. Knowles, M.D.
Treasurer.....Janis Gailitis, M.D.
Delegates.....Philomen P. Ciarla, M.D.
Charles S. Dotterer, M.D.
Councilor.....John M. Malone, M.D.
Alternate Councilor.....Robert L. Bestoso, M.D.
Censors.....Samuel Adelson, M.D.
James C. Callahan, M.D.

At this meeting of the Society Doctor James Bowes of 548 Bristol Ferry Road, Portsmouth, was elected an active member.

Respectfully submitted,
Richard R. Knowles, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

The 114th Annual Meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, January 2, 1961. The meeting was called to order by the president, Doctor Irving A. Beck, at 8:30 P.M.

Minutes of December Meeting

The reading of the minutes of the December meeting was omitted.

Annual Report of the Secretary

Doctor William A. Reid read his annual report which included, among other matters, a list of members who had died during the year. The president called for the membership present to stand in a moment of silent prayer for these deceased doctors.

The complete report of the secretary was accepted and placed on file. Copy is made part of the official minutes of the meeting.

Annual Report of the Treasurer

Doctor Frank I. Matteo, treasurer, read his annual report, copy of which is made part of the official minutes of the meeting. The motion was made, seconded and adopted that the report be received and placed on file.

Election of Officers for 1961

The secretary reported that there were no counter nominations for the slate of officers submitted to the membership with the notice of the December meeting. Therefore, he moved the election of the slate as submitted. The motion was seconded and adopted.

Doctor Beck named Doctors Frank Matteo and William Corvese to escort Doctor Frank D. Fratantuono, the new president, to the rostrum. Doctor Fratantuono briefly expressed his appreciation for the honor conferred upon him by the members of the Association.

Presidential Address

Doctor Irving A. Beck gave his Presidential address under the title of *The B.M.R. of Your Association,* in which he reviewed the participation of the Association in the activities of the Rhode Island Medical Society and more particularly in the history, development, and maintenance of the Rhode Island Medical Society Library.

Report of the Executive Committee

Doctor Reid presented the following report from the Executive Committee:

At a recent meeting the Executive Committee took the following actions,

1. It approved of the application of Doctor Jan S. Dudek, of Johnston, and it voted to recommend his election to active membership at the meeting of the Association on January 2, 1961.
2. It voted that Doctors Arnold Porter and Robert R. Baldridge should be the Association's official delegates to the Rhode Island Council of Community Services.
3. It reviewed and approved of the financial statement of the treasurer for the year 1960.
4. It voted to recommend that the annual dues for active members be $50 and for associate members, $5.

He moved the election of Doctor Dudek to active membership and the adoption of the report of the committee and the recommendations contained therein. The motion was seconded and passed.

Presentation of Membership Certificates

Doctor Beck presented membership certificates

to the two physicians who were elected to active membership at the December meeting of the Association.

Announcements by the President

Doctor Beck announced medical lectures to be held at Providence College and at the John Hay Library at Brown University within the month.

Lecture by Doctor Simeone

Doctor Beck expressed the appreciation of the officers and the program committee to Doctor F. A. Simeone, professor of surgery at Western Reserve University and director of surgery at Cleveland Metropolitan General Hospital, a native of Providence and a graduate of Brown University, for coming to Providence to address the Association on the occasion of its annual session. Doctor Simeone spoke on *The Contributions of Surgical Research to Human Physiology.*

He reviewed the history of classical contributions to physiology and pathological anatomy by such leaders as John Hunter and William Beaumont, spoke of more modern observations of similar nature and described some of his own work. A full text of his paper will be published in the RHODE ISLAND MEDICAL JOURNAL.

Adjournment and Collation

At the conclusion of the program, collation was served in the basement dining room.

Attendance was 87.

Respectfully submitted,

WILLIAM A. REID, M.D., *Secretary*

* * *

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, December 5, 1960. The meeting was called to order by the president, Doctor Irving A. Beck, at 8:35 P.M.

Minutes of November Meeting

Doctor Beck stated that the minutes of the November meeting would be published in the RHODE ISLAND MEDICAL JOURNAL, and therefore they would not be read at this time unless there was a request for a reading.

Report of the Secretary

Doctor Reid reported that the Executive Committee recommended for election to active membership the following: Jorge Benavides, M.D., and Alfred Toselli, M.D.

A motion was made, seconded, and passed that these two physicians be elected to active membership.

Doctor Reid reported that, in accordance with the bylaws, the Executive Committee had prepared a slate of officers and had submitted it to the members with a notice of the December meeting. Counter nominations to this slate must be submitted within ten days of the Annual Meeting to be held on January 2, 1961, at which time, he noted, the election of officers for 1961 would take place.

The secretary read a resolution received from three members of the Association which had been submitted to the Executive Committee. The resolution was as follows:

WHEREAS, the Providence Tuberculosis League has been for many years a source of pride to physicians and laymen alike, and

WHEREAS, said Providence Tuberculosis League has been supported and is now supported with great confidence by the doctors of Rhode Island, and

WHEREAS, the support of this Association has been demonstrated and made known in innumerable ways, and

WHEREAS, the RHODE ISLAND MEDICAL JOURNAL has stated, "The people of Providence, physicians and laymen alike, have every reason to take pride in the accomplishments of the Providence Tuberculosis League. It is outstanding among organizations of its kind in the United States . . . its mobile unit . . . has done pioneer survey work in Providence . . . its value is proven. The Tuberculosis League is showing us the way, backed by the doctors of Providence."

Now, therefore, be it resolved that we do reaffirm our support for the Providence Tuberculosis League and agree that its continued existence and efficient operation is in the best interests of the Providence community.

Doctor Reid reported that the Executive Committee had reviewed the study of the Providence Tuberculosis League made by the Rhode Island Council of Community Services and had also reviewed a dissenting report to this study submitted by four members of the Providence Medical Association. He reported that the Executive Committee had taken the following action regarding the resolution:

The Executive Committee endorses this resolution and thereby the work of the Providence Tuberculosis League, and it believes the League should continue its operations only until such time as other appropriate State or local agencies indicate that they are willing, ready and capable, in the judgment of this Association, to provide the same level of service as the Providence Tuberculosis League now offers to the people of this community.

continued on next page

He also reported that at a special meeting of the Executive Committee held this evening the objection of the sponsors of the resolution to the inclusion of the word *only* in the statement appended to the resolution by the Executive Committee had been voiced but the Executive Committee, by a majority vote, felt that the word *only* should be retained.

He moved the adoption of the resolution with the statement of the Executive Committee appended to it. The motion was seconded.

Doctor Elihu S. Wing discussed the motion and moved the adoption of the resolution with the statement of the Executive Committee appended to it but with the omission of the word *only* from the Executive Committee's statement. The motion was seconded.

There was general discussion of the motions.

A motion to table the motions before the Association was made, seconded, and defeated.

The motion to adopt the resolution with the omission of the word *only* from the Executive Committee report appended to it was defeated on a division vote.

The original motion to adopt the resolution with the Executive Committee statement was adopted.

Announcements by the President

The president announced that within recent weeks the Association had lost by death Doctors John H. Brothers and Mihran Missirlian. The members stood in a moment of silent prayer in memory of these doctors.

The president announced that the Program Committee had secured Doctor F. A. Simeone, of Cleveland, to be the guest speaker at the 114th Annual Meeting to be held on Monday, January 2, at the Medical Library.

Doctor Beck announced that Providence College invites the members of the Association to hear Professor James Walter Wilson, of Brown University, in a lecture on Monday, December 12, at the Science Building at the College. This lecture is one in a series of the Honors Science Program supported by the National Institutes of Health.

Awarding of Membership Certificates

Doctor Beck awarded membership certificates to the members elected to active membership in the Association at the November meeting.

Resolution on Health Director

Doctor Thomas Perry submitted the following resolution:

WHEREAS the office of State Director of Health is one of greatest importance to the people of Rhode Island, and

WHEREAS the Providence Medical Association has long maintained that the office of director of Public Health at all levels in our government, state and municipal, should be nonpolitical in the best interests of the public generally, and

WHEREAS the increased interest in recent years by many community organizations and informed citizens has resulted in appropriations for tax funds to provide salaries to attract full-time career-type personnel who may continue to expand and improve the public health services for all citizens,

THEREFORE, BE IT RESOLVED that the Providence Medical Association, in meeting this fifth day of December, 1960, express its sincere hope that the governor-elect and the new General Assembly will continue the policy of selection of public health executive personnel on the basis of their specialized training and experience in this field, in order that the department may render the finest standard of public health service to the citizens of Rhode Island.

It was moved that the Association adopt the resolution and submit a copy to the governor-elect of Rhode Island. The motion was seconded and adopted unanimously.

Scientific Program

Doctor Irving A. Beck introduced Doctor Louis A. Leone, director of Cancer Research at Rhode Island Hospital, who gave a lecture on the subject of *The Role of Chemicals in the Treatment of Advanced Cancer.*

Doctor Leone spoke chiefly of the alkylating agents and emphasized that chemotherapy is aimed at palliation of symptoms in advanced cancer. There is no evidence that life is prolonged except in leukemia and lymphoma. He then explained the effects on cell metabolism, described the alkylating agents now in use and outlined the dosage scheduled for Thio TEPA.

The full text of Doctor Leone's paper will appear in a subsequent issue of the RHODE ISLAND MEDICAL JOURNAL.

The meeting adjourned at 10:20 P.M.

Collation was served.

Attendance was 86.

Respectfully submitted,

WILLIAM A. REID, M.D., *Secretary*

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A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, November 7, 1960. The meeting was called to order by the president, Doctor Irving A. Beck, at 8:30 P.M.

Minutes of the October Meeting

The president reported that the minutes of the October meeting as well as the Clinicopathological Conference report would be published in the RHODE ISLAND MEDICAL JOURNAL; and, therefore, a reading would be omitted unless there was a request for one.

Report of the Secretary

At a recent meeting the Executive Committee of the Association took the following actions:

1. It approved of plans of the Program Committee for meeting in 1961.
2. It referred to the Council of the state medical society an inquiry relative to the formation of a Medical Assistants Association in Rhode Island.
3. It voted that it should recommend the establishment of utilization committees in general hospitals in the Greater Providence area, as proposed in the report of the Medical Ecomics Council that was submitted to the House of Delegates of the Rhode Island Medical Society.
4. It held a hearing on the study report of the Providence Tuberculosis League, and it voted that the complete study report, and a dissenting report, be submitted to each member of the committee for further study and for possible recommendation of action on the matter to the Association.
5. It approved of the applications for active membership in the Association of: Louis A. Leone, M.D.; Sui Yen Wang, M.D.; and Charles E. Weinstein, M.D.

Announcements by the President

Doctor Irving A. Beck made the following announcements:

1. Relating to the Interim Meeting of the Rhode Island Medical Society to be held at the Squantum Club, in East Providence, on November 9;
2. Relating to the Inaugural lecture in the Distinguished Lecturers in Science Series sponsored by Providence College to be held on November 14 at the College with Doctor Sidney Farbar as the speaker.
3. Relating to the Third Annual Pharmacy Clinic at the University of Rhode Island on November 15 and 16 to which Rhode Island physicians are invited.

Awarding of Membership Certificates

Doctor Beck awarded membership certificates to the physicians elected to active membership at the October meeting of the Association.

Scientific Program

The president introduced Doctor Mark Altschule, assistant clinical professor of medicine, Harvard Medical School, and director of internal medicine and of research in clinical physiology, McLean Hospital, and also editor-in-chief of Lippincott's Medical Science, who spoke on the *Chemical Aspects of Psychiatry*. The RHODE ISLAND MEDICAL JOURNAL plans to publish the address.

Adjournment

The meeting was adjourned at 9:40 P.M.
Attendance was 105.
Collation was served.

Respectfully submitted,
WILLIAM A. REID, M.D., *Secretary*

WASHINGTON COUNTY MEDICAL SOCIETY

The Annual Meeting of the Washington County Medical Society was held in the Doctors' Room of the Westerly Hospital on Wednesday, January 11, 1960.

In the absence of Doctor Grainger, the president, Doctor Nestor, the first vice-president, called the meeting to order at 11:25 A.M.

The minutes of the previous meeting having been circulated to the membership by mail, and there being no corrections, deletions, or additions, they were accepted as published.

The application of Doctor Joshua Park was passed by the Board of Censors and he was voted into the society unanimously.

Since the Rhode Island Medical Society has been trying for some time to learn how many of the members of the Washington County Society were members of the parent society it was decided to send to the parent society a list of our membership and at the same time try to poll our membership to see for our own benefit just how many are such members.

Doctor Tatum who is attempting to compile a history of the Washington County Society requested some interesting facts about the society, particularly during the war years, from any member who might have same.

Before proceeding further with the meeting, since this was the Annual Meeting at which a new slate of officers is proposed, a committee composed of Doctors Jones, McGrath, and Gongaware was appointed by the Chair to retire and return with the new slate.

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WASHINGTON COUNTY MEDICAL SOCIETY

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Doctor Morrone raised the possibility of cutting the meetings in number to two (2) a year chiefly because of the slackening attendance. After a short discussion it was decided that it would be best to leave it as it is at the present, four (4) meetings a year.

The Treasurer's Report was presented by Doctor Tatum and accepted as presented.

A motion by Doctor Gongaware and seconded by Doctor Jones to buy seven (7) more shares of the stocks presently held by the society to make it an even fifty (50) shares passed by a vote of twelve (12) to seven (7). Doctor Agnelli objected to this plan and thought rather that the society should sell its stocks and use the proceeds for some worthy purpose. Doctor Eckel remarked that since we have no project in the immediate offing, we should invest until such time as one was proposed. Doctor Morrone suggested appointing a committee to investigate and discuss such plans.

A motion by Doctor Morrone and seconded by Doctor Agnelli to appoint such a committee was passed unanimously. The committee proposed was Doctor Tatum in conjunction with the Executive Committee.

The secretary was requested to poll the membership for ideas.

A question arose that since the parent society was including in its dues premium notice a request for contributions to the Benevolence Fund should the treasurer of our society also include such notices in her dues request. A motion by Doctor Agnelli, seconded by Doctor Celestino, to have the treasurer keep up the established procedure was carried by those present.

The appointed committee returned the following slate of officers:

President ..... James McGrath, M.D.
First Vice-President ..... Louis Morrone, M.D.
Second Vice-President ..... William Tully, M.D.
Secretary ..... John Walsh, M.D.
Treasurer ..... Julianna Tatum, M.D.
Councilor ..... Samuel Nathans, M.D.
Delegates
To 1962 ..... F. Bruno Agnelli, M.D.
To 1963 ..... Hartford Gongaware, M.D.
To 1964 ..... James McGrath, M.D.
Censors ..... Clifford Hathaway, M.D.
Hayes Cluxton, M.D.
Dominic Chimento, M.D.
Auditor ..... Salvatore Turco, M.D.
Executive Committee ..... Henry Grainger, M.D., ex-officio
Pasquale Celestino, M.D.
John Jones, M.D.

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There being no objections, additions, or deletions the secretary was instructed to cast one vote for the assembled. Same was done and the newly appointed president assumed charge of the meeting.

There being no new business to discuss, the Business Meeting was adjourned at 12:08 P.M.

Doctor Earl J. Mara, the president of the Rhode Island Medical Society, was introduced to the gathering and he addressed the assembly on an informal basis.

Respectfully submitted,

JOHN J. WALSH, JR., M.D., *Secretary*

WOONSOCKET DISTRICT MEDICAL SOCIETY

The annual meeting of the Woonsocket District Medical Society was held at 8:30 P.M., December 7, 1960, in the Woonsocket Hospital Cafeteria. Doctor Victor H. Monti presided.

Due to the length of the speaking program the regular portion of the business meeting was postponed until a later date.

The first speaker was Doctor Harold L. Bedoe, chief medical examiner of the state of Rhode Island. Doctor Bedoe gave a history of the role of the coroners and their subsequent change to the Medical Examiners' system. He also went into detail on the types of death that should be reported to the Medical Examiner's office. In summary, this type of death was one in which there was no doctor in attendance or in case of sudden or violent death.

Doctor Eske Windsberg, chief surgeon at the Miriam Hospital and consulting physician at many other hospitals in Rhode Island, gave a talk on the surgical treatment of acute obstruction of the colon due to cancer in the distal one half of the colon. This was the same paper that he had delivered in the Florida meeting of the American College of Surgeons.

In essence, the Windsberg System of treating complete obstruction of the lower one half of the colon is a one-stage repair. This type of repair is necessary because of the poor results often obtained from a two-stage repair. The essential part of the Windsberg procedure is a thorough preparation of the bowel before the primary anastomosis is made. For further details of technique consult the Journals of A. S. G. & O., June issue, or the reports in the RHODE ISLAND MEDICAL JOURNAL.

* * *

After the annual meeting of December 7, Doctor Monti appointed the following Nominating Committee to select officers for the coming year: Doctor Carlo DeStefani, Doctor Philip J. Morrison, and Doctor Leo Dugas.

The Nominating Committee reported their recommendations at a Special Meeting of the Society held on December 19, and the proposed slate of officers was elected without opposition.

President.....EMIL A. KASKIW, M.D.
Vice-President.....EUCLID L. TREMBLAY, M.D.
Secretary.....ALTON P. THOMAS, M.D.
Treasurer.....PAUL E. BOUCHER, M.D.
Councilor.....RICHARD H. DOWLING, M.D.
Delegates.....SAUL A. WITTES, M.D.
JOSEPH A. BLISS, M.D.
EDWARD B. MEDOFF, M.D.
to serve until December, 1962
Censors.....VICTOR H. MONTI, M.D.
AUREY FONTAINE, M.D.
EDWARD B. MEDOFF, M.D.

Respectfully submitted,

ALTON THOMAS, M.D., *Secretary*

THE WHITE HOUSE CONFERENCE ON AGING, 1961

JOHN E. FARRELL, SC.D.

The Author. *John E. Farrell, Sc.D., of Providence, Rhode Island. Executive Secretary, the Rhode Island Medical Society and the Providence Medical Association; Past President, Medical Society Executives Association, and the New England Health Education Association.*

THE FIRST White House Conference on Aging was characterized in advance by *President Dwight D. Eisenhower* as "a significant effort to find better ways to enlarge opportunities for our older people." *Arthur S. Flemming,* secretary of Health, Education and Welfare, called it an "effort directed to solving the major problems confronting the nation's older people, and to developing programs and policies that will make life better for the older people of the future." *Robert W. Kean,* chairman of the National Advisory Committee for the Conference, said it would "provide a meeting ground for thoughtful, forward-looking Americans who are concerned with the conditions that confront many of our senior citizens," and that while "most problems in the field of aging can best be solved by action at the state and local levels, there are areas, however, where the Federal government can contribute."

With this approach in mind, thousands of American citizens participated in local and state conferences on aging, studied the many complex problems presented, and, in the words of *Bertha S. Adkins,* under secretary of Health, Welfare and Education, contributed "time, energy, imaginative thinking, devotion and plain, old-fashioned hard work."

The national conference, therefore, was to be a crystallization of the significant points of agreement arrived at in the state conference. Approximately 2,600 delegates were to meet in Washington January 9-12, 1961, with the understanding that through work groups, sections, group and plenary sessions, they would discuss and act only on the subject matter and the recommendations of the states, without reference to specific pending legislation.

A "Grass Roots" Opinion?

The individual states for the most part undoubtedly developed state conferences at which significant points of agreement were arrived at by local citizens on all the various subject matters that were listed for subsequent discussion at the White House Conference. However, the local or "grass root" agreements were thoroughly dissipated in the group dynamics that dominated the Washington meeting of the delegates from the states, and from national voluntary and public health, welfare and educational agencies.

This is what happened. Each of the approximately 2,600 delegates was assigned to one of twenty major sections, each of which was responsible for discussion in one particlar subject matter area, i.e., Health and Medical Care; Income Maintenance, Education, Housing, etc.

Each section in turn was divided into small work groups ranging in size up to approximately forty delegates. All work groups and sections had officially designated chairmen, discussion leaders, recorders, and resource consultants. For a full day delegates in the work groups had the opportunity to express opinions freely, arguing for support of personal ideas, and presumably reflecting the recommendations of their own states. The actions taken by these various small work groups were then consolidated (by the work group chairmen of a section) into a policy and this draft was submitted to the entire section for its action.

The vote of the section became the final vote, and the action taken became the basis for one phase of the final report submitted at the closing Plenary Session as the White House Conference Report, but no voting on any of the report recommendations was allowed at this closing meeting.

To illustrate the force of such group dynamics consider the subject of financing of medical costs which was one of the topics under Income Maintenance in Section 2. The delegates assigned to this section were first oriented to their topic by the chairman, Charles I. Schottland, former federal social security official, and now a professor at Brandeis University, who indicated a widespread concern about the problems of medical care costs of the aged by the states.

Note in Professor Schottland's remarks and posed questions below how subtly the audience could be oriented to consider any means test for

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the distribution of public tax funds to potential recipients as a degrading action—a test of indigency, as he characterizes it.

"Many of the recommendations express the principle of individual and family responsibility, with involvement of government — and particularly the Federal government — only as a last resort and only for those who can pass a test of indigency. We would all agree with the values of individual and family self-reliance and responsibility.

"With reference to one of the controversial matters before our work groups, however, namely medical care, we must ask ourselves several questions. Is this sense of individual responsibility strengthened by forcing old people to pass a test of indigency before they receive needed medical care? And is the family and society in general strengthened if adult children must deprive their own youngsters or must use savings put aside for their own old-age security in order to pay for medical care for an aged parent? Our answers may reflect a difference of opinion, but we should not glibly make generalizations about these matters without considering these questions."

In the subsequent work group meetings of this section, (seven small groups) the question of financing medical care costs through voluntary means, and with government assistance to the states, as provided in the legislation enacted by the Congress in 1960, was opposed by those who favored the addition of medical care costs to the social security system. The emotional argument of a means test versus social security benefits "provided as a right" was in the forefront, with few delegates heard by this reporter indicating much, if any knowledge of what a proper means test would be, and the fact that the Veterans Administration has such a test, and that the method is an accepted part of many federal programs, such as assistance to the blind, small business loans, aid to permanently disabled, and old age assistance. It is also utilized at the state level for state-sponsored programs.

Six of these small work groups voted in favor of the social security system approach to meeting medical care costs, and one group rejected the proposal. Then the recommendation was incorporated as one of several for consideration by the section, which was to take the final vote on the matter of financing medical care, as follows:

"It is the recommendation of the majority that to assure adequate health care for the aged with certainty and dignity, there should be established a basic program for financing health care for the aged within the framework of the Old Age Survivors and Disability Insurance System.

"A minority oppose the use of the OASDI method.

"Both those who place major reliance on the Social Security mechanism and the others agree that:

(a) The medical assistance for the aged program adopted by the 86th Congress should be promptly implemented by the states.

(b) Voluntary prepayment methods should be used to their full potential.

(c) In all programs, the individual's freedom, dignity and self-respect should be protected.

(d) Individual responsibility, self-reliance and thrift in preparing for later years should be encouraged."

The resolution was adopted by a standing vote of 170 to 99.

Thus by the 71 delegate majority vote in this section the public at large would be of the opinion that the action represented the thinking of the entire Conference, since the estimated 2,600 delegates could not vote contrary when the final report was submitted at the concluding plenary session. Thus the sincere people who contributed their time and thinking to the problems of the aging may well be wondering why they made the trek to Washington, because it was evident that many of the "solutions" sought had already been basically predetermined by those setting up the program.

Stacked Sessions?

The pre-conference publicity was featured by statements by former Congressman Aime Forand of Rhode Island, and Professor Wilbur Cohen, Michigan educator and former social security official, that the sessions on financing medical care would be stacked to defeat the idea of paying for medical costs through social security. At the opening plenary session on Monday, January 9, Senator Pat McNamara, in a keynote address to all the delegates, added to the smear campaign against American physicians and dentists with such statements as —

"... Apparently — one tactic of the campaign in this conference — is the placement of A.M.A. — oriented delegates in sufficient strength in certain work groups to give the nation the impression that the conference does *not* favor such medical insurance.

"According to a breakdown of available figures from the Department of Health, Education and Welfare, for example — 92 per cent of the doctors and dentists in Group One of this conference — have been assigned to the work group in financing medical costs. In this group alone, one out of every three delegates represents the medical or dental, or insurance professions. ..."

A statistical breakdown, as of December 29, 1960, available to reporters, showed there were then 2,512 Conference delegates. A breakdown of the total, *by occupation,* was —

Business Executives	267
Physicians and Dentists	283
Other Health Service	153
Education	353
Insurance	45
Social Welfare	368
Labor Organization	132
Clergy & Religion	219
Other	630
Not Reported	62

Section 2 which took the final vote on the matter of financing medical costs, as reported above, had the following assignments as of December 29:

Business Executives	34
Physicians & Dentists	28
Other Health Service	9
Education	19
Insurance	26
Social Welfare	36
Labor Organizations	41

Clergy & Religion	13
Other	48
Not Reported	3

Group I, to which Senator McNamara referred, had four sections, as follows: (1) Population Trends and Social and Economic Implications; (2) Income Maintenance; (3) Impact of Inflation on Retired Citizens; (4) Employment Security and Retirement.

If it is true, as Senator McNamara stated, that 28 of the 30 physicians and dentists registered to Group I were assigned to the section on income maintenance, we see no grounds for the conclusion the Senator tries to make. Physicians established Blue Shield and predominate on the directing boards of the 74 such plans in the nation, and logically would be assigned to a group discussing medical care costs rather than to one for consideration of employment security, population trends, or inflation impacts.

The most remarkable thing to your reporter is the fact that no one apparently called to Senator McNamara's attention—or to the public's for that matter—that while only *one tenth* of *all* the *physicians* and *dentists* attending the *entire* Conference were assigned to Section 2, which considered the matter of financing medical costs, *almost one third* (41 of 132) of the representatives of *labor organizations*, who are most vociferous about adding to the social security system, were assigned to Section 2!

Rebuttal by Congressman Fogarty

The premeditated and certainly unwarranted attack on American medicine, dentistry, and insurance by Senator McNamara was challenged by Congressman John E. Fogarty of Rhode Island, drafter of the White House Conference legislation, whose keynote address, following that of Senator McNamara, contained the following:

"The charges of the Conference being 'stacked,' 'loaded,' or that the delegates are 'ganging up' are serious and insulting to the trust the nation's citizens of all ages have placed in your hands to consider solutions to the problems that have or will confront every one of us in due time.

"I am certain it was not the intention of the 'accusers' or these ill-advised critics, but I believe they have challenged the integrity of everyone of us. We now have an additional assignment to prove the falsehood of their statements.

"I have no patience and very little respect for any one who would place politics, personal or professional prejudices and greedy, self-interests ahead of positive action for our nation's older citizens."

* * *

Although only ten of the thirty states making specific recommendations regarding financing of medical care of the aged favored the social security tax, the Conference planners assigned keynote speakers who certainly failed to read, or ignored, the stated General Rules of Order that "Discussion and action in all meetings (underscoring added) shall be based on subject matter and the recommendations of the states, without reference to specific pending legislation."

Thus we had at section meetings on the first day keynoters such as former secretary of Health, Education and Welfare, Marion B. Folsom, stating

"The logical plan, and one which is endorsed by most students of the subject, is to finance and administer a program of health insurance for retired people through Old Age, Survivors, and Disability Insurance Program. . . ."

The majority of the states made no such recommendation, but Mr. Folsom goes along with "most students of the subject," whoever they may be, and thus by generalization influenced the listening audience to his personal views.

Again, with disregard for the "grass root" reports from the majority of the states, *Governor Robert B. Meyner* of New Jersey used his political position to make any program other than the social security plan undignified, and any check on the distribution of tax collected funds morale shattering, by telling the delegates that

"The only practical way to accomplish this aim (financing the cost of medical care) on a dignified, sound fiscal basis, it seems to me, is to extend the social security system to include medical insurance for America's senior citizens. This approach will permit the ordinary person, during the course of his working life, to pay a small premium — a few cents a day — and have a paid-up medical insurance policy upon retirement. This would be an earned right — not a morale-shattering charity handout."

The glowing generalization of Governor Meyner that citizens would have, for a few cents per day, "a paid-up medical insurance policy upon retirement" hardly stands up when one considers that these same oldsters were told years ago that their small contributions to the social security system would give them a cash income that would allow them to live in comfortable retirement with a minimum of financial worries. As *George Meany*, president of the A.F.L. and C.I.O., stated in his address, ". . . the man who retired in 1940 could buy as much with his $22 check as he could buy in 1959 with $49."

The same Mr. Meany, however, used his time to advantage in castigating the American Medical Association because it supported the voluntary approach to the financing of medical care costs, with the aid of the government program passed by the Congress of the United States in 1960.

Apparently anyone, the Congress included, who does not agree with Mr. Meany's ideas is negative and hostile, and offers the public only "inadequate, unwieldy and unrealistic" ways in which to pay their medical care costs. Apparently labor's view must not be challenged when it states that

"Labor is not wedded to the explicit provisions of the Forand Bill, the McNamara Bill or any other particular piece of legislation. The workers of this country seek only a good and workable plan. They

continued on next page

are convinced that the basis of such a plan can be found only in the Social Security System, which is financially sound and administratively capable of handling this huge job."

Labor Celebrates a "Victory"

The required acceptance, in accordance with the Conference rules, of the Section 2 report by all the delegates at the final plenary session without vote, was apparently hailed as a major victory by the labor organization groups. The Washington bureau of the PROVIDENCE JOURNAL-BULLETIN reported in the BULLETIN of Friday, January 13, as follows:

Forand Sees Victory for Health Plan

Former Rep. Aime J. Forand yesterday predicted that Congress this year will pass legislation embodying his plan for extending Social Security into the health insurance field.

He spoke at a victory rally held by delegates who earlier in the day succeeded in getting the White House Conference on Aging to endorse the Social Security approach to medical insurance. The rally was sponsored by the A.F.L.-C.I.O. and the National Association of Social Workers.

Mr. Forand, who refused a last-minute invitation to attend the conference on the ground that it was "stacked" against his plan, said steps are being considered to rally public opinion behind the conference endorsement to win passage of necessary legislation.

Such steps might include use of the national organization of Senior Citizens for Kennedy Committee, which Mr. Forand headed during the recent election campaign, it was indicated.

Sen. Paul Douglas, D-Ill., told the conference before it adjourned that a "large share of the ultimate victory" of the fight for a Social Security medical plan was due to Mr. Forand.

He said he was surprised at the outcome of the conference but felt that its endorsement resulted from "the compulsive power of truth." But, he added, "truth by itself doesn't win." He said more hard work would be needed to achieve passage of the plan by Congress.

He urged the group to use the "time-honored methods of influencing public opinion," and added: "Congress finds it impossible to stand out against an energetic, educated public opinion."

Positive Health for the Aging

In sharp contrast to the propagandists who used their platform assignment as an opportunity to further their espousal of the federal social security system, *Doctor Leonard W. Larson*, president-elect of the American Medical Association and chairman of the Section on Health and Medical Care, devoted his time to a review of programs for "positive health for the aging." After pointing out that the recommendations from the various state conferences were, on the whole, "well thought out and reflected a good deal of careful effort," Doctor Larson stated —

"I think it is unfortunate, however, that four of the sub-topics assigned to our work groups are concerned with the care of the sick, and only one is devoted to the preservation of health. I regret that this necessary subdivision tends to stress treatment at the expense of prevention — to direct attention to the sick and to disregard of the well — and to emphasize organized programs at the expense of individual initiative and responsibility.

"... We must do more than *react* to the minority of older persons who are ill — we must *act* for the great majority who are well. We must shift our emphasis from *defense* to *offense*.

"(This) will demand a whole new emphasis on the individual's responsibility for his own health — on the basis of good nutrition, sufficient exercise and healthful living habits which he can, and must follow throughout his own life."

* * *

The Hospital Association Viewpoint

In a presentation of the subject *Institutional Care and the Community*, in which he reviewed the need for sound community planning by all groups, the types of institutions involved in the care of the aged, and special services for the aged, *Doctor Edwin L. Crosby*, director of the American Hospital Association, offered this comment on the financing of hospital care:

"Prepayment plans of Blue Cross and commercial insurance have contributed considerably, and the recently enacted Kerr-Mills legislation will give material assistance when properly implemented by the states. But other sections of this conference are concerned with this problem, and I will say no more about it except to point out that a specific means of financing must be viewed in the light of its impact on a specific institution.

"For instance, if a prepayment group or government-sponsored program will pay only for care in the hospital, then all aged patients, whether or not they really need intensive care, will enter the hospital. This means our hospitals could be glutted with long-term patients, when these same patients would better be in a nursing home at considerably less cost. But if these same programs will pay for nursing home care, are there enough facilities available? Are their standards of care high enough?

"In discussing the questions of financing, try to think in terms of availability of facilities and utilization of these same facilities."

Compulsory Health Care Rejected

When the policy statement and recommendations of the Health and Medical Care Section were discussed and adopted an amendment introduced from the floor relative to the recommendation on Institutional Care was adopted by a vote of 165 to 120, as follows:

"Existing Federal-State matching programs will provide effective, economical, dignified medical care for our elderly who need help.

"These should and will be implemented by State legislatures. Compulsory health care inevitably results in poor quality health care."

* * *

The undue emphasis on the social and economic aspects of aging was given so much prominence the Conference almost forgot what it is that makes old age a special problem, *Doctor Theodore G. Klumpp*, president of Winthrop Laboratories, commented at one special meeting of the delegates.

"... Basically, what does it profit a man to have a wad of insurance policies, elegant public housing, income maintenance and social security to the hilt for his old age, if he arrives at that state broken and decrepit in body and mentally senile," he said. "Custodial care for what remains of the mind and body? Yes, of course. But shouldn't we set our sights on a more exalted objective. Shouldn't we concern ourselves more intensely with the problems of health maintenance with the objective that more of our people arrive at their destination sound in body and mind. And if this were to come to pass wouldn't many of the socio-economic problems fade in significance?"

Scope of Conference Discussions

As Doctor Klumpp noted, the focus of too much attention was on financing of medical care. However, many excellent group meetings were held during the week at which the problems of employment, housing, rehabilitation, education, free time activities, religion, and research, as related to the aging population, came in for careful scrutiny.

A most interesting statistical evaluation of the financial value of continued employment beyond the retirement age was made by *Mr. Dwight S. Sargent*, personnel director of the Consolidated Edison Company of New York, in his address at one of the special meetings. Said Mr. Sargent:

"My estimate is that possibly 90% of the 19 million people covered by private pension plans have to retire at age 65. In the group, again, I would estimate that 2%, or about 380,000, come up for retirement each year. 10% of these can continue working. So 90% of 380,000 would leave approximately 340,000 who have to retire as soon as they are 65 whether they like it or not. Based on our own experience of ⅓ electing to continue, possibly 100,000 to 110,000 if given a choice, would elect to continue working.

"I think this figure is conservative, as I know a number of companies who allow a free choice, where 50% or more elect to continue.

"So, if 110,000 continued working just one year beyond 65, the following would be the result:

Social Security would not pay out (\$80 Primary Benefit + \$40 Wife's Benefit)	\$158,000,000
Private pension plans would not pay out (Estimate based on Company pension of \$100/month)	132,000,000
Individuals would continue to pay Social Security Tax	13,000,000
Federal and State Income Tax (Estimate based on \$5000/year salary)	55,000,000
Continued earnings from full employment (Based on \$5000/year average earnings)	\$550,000,000

"It thus seems to me that these results are all on the plus side from the point of view of the economy and the individual."

In an appraisal of "Education, Aging and Meaningful Survival," Dr. Edward L. Bortz, chief of Medical Service at The Lankenau Hospital in Philadelphia, indicated that a stock-taking is needed to determine where we stand in our thinking, are current customs adequate as we face the future, and are present educational forms efficient in structure, content and personnel.

"Aging", he cited, "is a dual phenomenon. We grow and we age, and in specific ways we recede. These aspects should be observed. Influences and habits which encourage health, growth and enjoyable living should be promoted. Present day practices and attitudes which limit human growth and flowering should be identified and where possible, corrected, such as misconceptions regarding older citizens in their present unfortunate status as deficit members of our national family. There is certainly a need for a thorough catharsis of our present cultural mores that are inadequate and restrictive."

* * *

In a scholarly paper titled *Spotlight on Research*, Dr. Ewald W. Busse, of the Center for the Study of Aging at Duke University, clarified the definitions of the term *aging*, listed the goals of medical research, and touched upon major areas of medical and dental research, concluding with the statement that

"Lastly, one should recognize that, in the field of aging particularly, there is a tendency to misinterpretation of research results. Because of the emotional influences inherent in the need for action, generalizations are often made on the basis of findings which are valid only for a relatively small sample of elderly persons. When such false generalizations are extended to our entire population, the result can be unfortunate social patterns and legal actions, and wasteful expenditures of time and money. The diversity of population within the United States is obvious, and the factors affecting the health and longevity of this population are numerous and varied. A few of these factors are genetic determinants, climate, nutrition, socioeconomic status, and education. All of these factors must be taken into consideration when health problems are being studied and methods for their prevention and treatment are being sought."

What Now?

Much of the good from the White House Conference may eventually flow back to the state levels for implementation of worthwhile recommendations by the local communities. The controversial issues, such as that of financing health care costs, will provide further fuel for the fires of the politicians and the socialization planners.

Labor organizations will undoubtedly back Senator McNamara in his political maneuverings to place compulsory health insurance before the Congress, and to further plans for an Aging Agency in the Department of Health, Education and Welfare.

Congressman Fogarty has introduced legislation calling for a five-member federal commission on aging to be appointed by the President. The Commission's first job would presumably be to implement the findings of the White House Conference

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on Aging, and beyond that to be responsible for continuing and co-ordinating all federal policies relating to elderly persons. The legislation would seek authorization of 70 million dollars in grants to the states over the next five years, plus 2 million dollars for state planning grants, and 5 million dollars for academic research grants. The proposed commission, backed by an 18-member advisory council, would administer the grants.

Wilbur J. Cohen, professor of Public Welfare Administration in the School of Social Work at the University of Michigan, submitted a task force report on social security to President Kennedy, with the recommendation included for federal coverage of hospitalization and nursing home care for the over age 65 citizens. Mr. Cohen was subsequently named by President Kennedy as assistant secretary for Legislative Matters of the Department of Health, Education and Welfare.

Undoubtedly this task force report, together with the White House Conference on Aging discussions, will be utilized freely in the coming months by the proponents of an additional compulsory tax addition to the social security program to provide limited hospital and nursing home care for eligible citizens over the age 65. The issue will probably be timed for a climax in the political year of 1961.

TREATMENT OF RESPIRATORY DISTRESS OF THE NEWBORN WITH HUMAN FIBRINOLYSIN

concluded from page 96

[3]Gitlin, D., and Craig, J. M.: The Nature of the Hyaline Membrane in Asphyxia of the Newborn, Pediatrics 17:64, 1956

[4]Gruenwald, P.: In Pulmonary Hyaline Membranes Report of the 5th M and R Pediatric Research Conference, Columbus, Ohio M and R Laboratories 1953, pg. 71

[5]Craig, J. M.; Fenton, K., and Gitlin, D.: Obstructive Factors in the Pulmonary Hyaline Membrane Syndrome in Asphyxia of the Newborn, Pediatrics 22:847, 1958

[6]*Idem.*

[7]Usher, Robert: The Respiratory Distress Syndrome of Prematurity, Pediatrics 24:562, 1959

[8]Born, G. V. R.; Dawes, G. S.; Mott, J. C., and Widdicombe, J. G.: Changes in the Heart and Lungs at Birth, Cold Spring Harbor Symp. on Quant, Biol. 19:102, 1954

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WEDNESDAY, MARCH 29, 1961

Cardiovascular Symposium

Under the Auspices of the
Rhode Island Heart Association and the
Rhode Island Medical Society

WEDNESDAY, APRIL 5, 1961

Cancer Conference

For Rhode Island Physicians Under the Auspices of the Cancer Committee, Rhode Island Medical Society

LIBRARY HOURS — DAILY
(Except Saturday and Sunday)
8:30 A.M. — 4:30 P.M.